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# *Voluntary Health Sector Working Papers 2002*

**(Volume 2)**

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Canada

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Office of the Voluntary Sector
Centre for Healthy Human Development
Population and Public Health Branch
Health Canada
P.L. 1908C1
8th floor Jeanne Mance Building
Tunney's Pasture
Ottawa, Ontario
K1A 1B4
Telephone: (613) 946-2067
Fax: (613) 954-5542
Website: www.hc-sc.gc.ca/hppb/voluntarysector

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## Erratum

***Voluntary Health Organizations in Canada: Public Involvement and Support Results from the 2000 National Survey of Giving, Volunteering and Participating***
Canadian Centre for Philanthropy, David M. Lasby, Don K. Embuldeniya, March 2002

**Executive Summary**
page 1, paragraph 1
the sentence that reads: "But Canada's voluntary health sector also includes community health centres, crisis intervention services, public health services such as recreation and sport programs, walk-in clinics and physical therapy centres, emergency medical services, and organizations that focus on specific health issues."

should read: "But Canada's voluntary health sector also includes community health centres, crisis intervention services, public health services, walk-in clinics and physical therapy centres, emergency medical services, and organizations that focus on specific health issues." *Recreation and sport programs are not part of voluntary health sector according to the classification system used for the NSGVP.*

**Executive Summary**
page 2, paragraph 2
the sentence that reads: "The 25% of Canadians who donated more that $69 during the year to health organizations accounted for 76% of the total value of health donations."

should read: "The 25% of Canadian **health donors** who donated more that $69 during the year to health organizations accounted for 76% of the total value of health donations."

**Executive Summary**
page 3, paragraph 3
the sentence that reads: "The 25% of Canadians who volunteered 72 hours or more annually to health organizations accounted for 85% of the total number of volunteer hours."

should read: "The 25% of Canadian **health volunteers** who volunteered 72 hours or more annually to health organizations accounted for 85% of the total number of health volunteer hours."

# *Voluntary Health Sector Working Papers 2002*

**(Volume 2)**

**Voluntary Sector and Strategic Frameworks Unit**
**Population and Public Health Branch**

# Table of Contents

**Foreword** ..... iii

**Introduction** ..... iv

**About the Authors** ..... v

**Executive Summary** ..... vi

**Volunteers Are Not All the Same: The Case of Health Organizations**
*Paul B. Reed*
*L. Kevin Selbee* ..... 1

**Health Human Resources: The Role of the Voluntary Sector**
*Jeff Carr* ..... 27

**Voluntary Health Organizations in Canada: Public Involvement and Support; Results from the 2000 National Survey of Giving, Volunteering and Participating**
*David M. Lasby*
*Don K. Embuldeniya* ..... 64

**Charitable Giving to Charitable and Non-Profit Health Organizations: Perspectives Provided from the (1997) National Survey of Giving, Volunteering and Participating**
*Angela Febbraro*
*Michael Hall* ..... 126

## Foreword

Canadians rely on and believe in the voluntary health sector. Voluntary health organizations build on the contributions of time and money of millions of Canadians to provide services in our communities, carry out research, advocate for improvement and raise funds, all in order to improve the well-being of Canadians across every population group and against every risk to health. They also build community capacity by involving Canadians as volunteers.

A majority of Health Canada's policy and program partners are voluntary organizations, and a substantial proportion of departmental expenditures is invested in the voluntary sector. While we know about the effectiveness of individual programs and organizations, there is little quantitative or qualitative evidence about the voluntary health sector itself. Because it is a key partner, we want to advance our understanding of this important sub-sector of what the Prime Minister has called the 'third pillar' of society.

The important contribution of the voluntary sector to the health of Canadians highlights the need for a comprehensive body of research on its role and impact in Canadian communities. Recognizing this, the Voluntary Sector and Strategic Frameworks Unit, Population and Public Health Branch commissioned a number of research papers. *Voluntary Health Sector Working Papers 2002* brings the papers together as a contribution to the understanding of the unique knowledge, perspective and expertise of Canada's voluntary health sector and its important place in Canadian life. The papers address knowledge gaps in government, academia and policy circles in Canada and internationally.

Volume 1 of *Voluntary Health Sector Working Papers 2002* consists of six papers on various aspects of the voluntary health sector, while the four papers in Volume 2 have as a common theme the results of the National Survey of Giving, Volunteering and Participating. The authors of these papers form a diverse group – community health workers, economists, policy experts, quantitative researchers, academics, and staff of Canadian voluntary sector organizations – and their work covers a broad range of topics.

The publication of these working papers also complements other current Health Canada and federal government initiatives to improve the delivery of health services to Canadians and to strengthen partnerships with the voluntary sector.

Health Canada would like to thank the authors of these papers and the organizations with which they are affiliated for their generous contribution to increasing our understanding of the vital part the voluntary health sector plays in maintaining and improving the health of Canadians. Thanks also go to Mary Jane Lipkin, Manager of the Voluntary Sector and Strategic Framework Unit and Karen Hill, Senior Analyst for bringing these papers to publication.

Amanda Cliff
Director General, Strategic Policy Directorate
Population and Public Health Branch
Health Canada

# Introduction

***An Important Contributor to Health and to Society***

Sometimes the contribution of Canada's voluntary health sector is highly visible, as underlined by the role of the Canadian Red Cross in post-September 11 emergency efforts in both Canada and the United States. At other times the contribution is as quiet and understated as the hospital volunteer who brings a warm blanket to someone who has just had surgery.

But whether the people and organizations that make up this sector are working in the spotlight or behind the scenes, the Voluntary Health Sector (VHS) in Canada is a huge contributor to the health of Canadians. And Canadians trust and believe in the VHS – each year, more than half of us donate to health charities, and the health sector receives the largest proportion of charitable donations made in all sectors.

However, despite being a major contributor to the health of Canadians, the VHS is poorly understood.

***Understanding the Sector***

We know the VHS is a major contributor to health research and generates many millions of dollars annually for research funding. However, very little focused research has been done on its role, size and composition. Unlike the funded health sector, we as yet have no comprehensive map of the voluntary health sector. As a consequence, the real role of the VHS in the health system has been largely unknown and undervalued.

First, what is the VHS? To put it simply, the VHS consists of organizations and volunteers that devote their efforts to improving human health. This is done in many ways – advocating health concerns, service delivery, research, public education, policy development and fundraising are just a few of them.

***The Working Papers***

As part of the federal Voluntary Sector Initiative, and in keeping with its commitment to knowledge development and research, Health Canada has published these working papers in *Voluntary Health Sector Working Papers 2002 (Volume 1* and *Volume 2)*. Each paper in these collections contributes to the beginnings of a body of knowledge about the role and responsibilities of the voluntary sector in health in Canada. As such they will help build interest in the development of a research agenda about and for the voluntary sector in health; they will inform policy and program development in the public and voluntary sectors; and, it is hoped, spark further research efforts into this important sector.

## About the Authors

**Jeff Carr** graduated from the University of Toronto with a Master's degree in Economics. For the past two years he has worked at Health Canada, where his research has focussed on labour issues in the health field and the sustainability of the health system. Jeff lives and works in Ottawa.

**Don Embuldeniya** is a Research Associate at the Canadian Centre for Philanthropy. He has worked in international development and social/human services fields, both in Canada and abroad. He has published several articles on Canada's civil society, economic reforms in Sri Lanka, and women and development. Don holds a M.A. in International Development from Clark University, Worcester, Massachusetts. He is currently a doctoral candidate at York University.

**Michael Hall** is Vice-President, Research at the Canadian Centre for Philanthropy. His many publications on nonprofit sector topics include Charitable Fundraising in Canada and Caring Canadians, Involved Canadians: Highlights from the National Survey of Giving, Volunteering and Participating. He is a member of the board of ARNOVA (the Association for Research on Nonprofit Organizations and Voluntary Action) and Co-chair of the Steering Committee for the Canada Survey of Giving, Volunteering and Participating. Dr. Hall holds a Ph.D. in social psychology from York University.

**David Lasby** is a Research Associate at the Canadian Centre for Philanthropy. He has worked as a field archaeologist specializing in lithic technology and quantitative methods in Jordan, England and Canada. David holds a M.Phil. from Cambridge University and is currently a doctoral candidate at the University of Toronto.

**Paul B. Reed**, Ph.D., is a Senior Social Scientist with Statistics Canada and a faculty member in the Departments of Law and Sociology/Anthropology at Carleton University in Ottawa. This study was done as part of the Nonprofit Sector Knowledge Base project, which Paul has directed since 1997. Paul's broader area of interest is contributory behaviour.

**L. Kevin Selbee** is a researcher with Statistics Canada and a Ph.D. student at Carleton University in Ottawa.

## Executive Summary

The four papers in Volume 2 are all based on results from the National Survey of Giving, Volunteering and Participating (NSGVP), in both 1997 and 2000. These papers, like those in Volume 1, are written from the unique perspectives of a diverse group of authors. As their short biographies indicate, these authors bring a richness of experience to this work.

The first paper in this volume, by **Paul Reed** and **Kevin Selbee**, is the first study of its kind regarding the heterogeneity of the voluntary sector in general, and both the distinctive and non-distinctive features of health volunteers in particular. The study was enabled by the strong features of the NSGVP, which combines an extent of both sample size and content which are unique in the world.

As the title of their study suggests, in "Volunteers are Not All the Same: The Case of Health Organizations," the authors compared the characteristics of individuals who volunteer for health organizations with those who volunteer for culture and recreation, social service and religious organizations. Three questions directed their inquiry. Do health volunteers differ from volunteers for other kinds of organizations? If so, how do they differ? Also, what characteristics do health volunteers have in common?

Among other findings, their analysis explains how health volunteers are significantly different from volunteers for culture and recreation organizations, but not very different from social service volunteers and volunteers from religious organizations.

This Reed and Selbee study suggests further inquiry needs to be done on, among other aspects: the social ethos of different types of volunteers; the logic involved in volunteer decision making – how and when and people decide to volunteer, for example; and, the link between formal and informal volunteering.

In "Health Human Resources: The Role of the Voluntary Sector," **Jeff Carr** looks at the contribution of the voluntary sector to health, focusing on two key questions. First, what is the economic value of the contribution of volunteers to the Canadian health care system? Second, what are the key determinants of voluntary behaviour? The result is a sketch of the scope of human resources provided by individual volunteers to health in Canada.

Carr examines two distinct categories of volunteers: formal volunteers and informal volunteers. Formal volunteers are those who donate their time through formally recognized organizations such as the United Way or the local hospital. Formal volunteers have been the focus of most study and contribute approximately 93 million hours each year compared to the 1.7 billion hours put in by those working for remuneration in the funded health sector. The second category of volunteer consists of informal volunteers, who work 2.3 billion hours annually and represent a resource even larger than the paid workforce. By comparing the economic value of contributions of volunteers to that of paid health workers, Carr comes up with a range of possible economic valuation that communicates the huge importance of the voluntary sector to the provision of health in Canada.

Using data from Statistics Canada and the NSGVP, Carr then moves to a closer quantitative examination of which factors are key determinants in deciding whether to volunteer, and if an individual does volunteer, how much time is spent on volunteer activities. Among a variety of factors including age and gender, for example, Carr finds that education is likely the single largest factor that determines whether or not an individual will volunteer.

Finally, Carr discusses the implications of his observations for intersectoral collaboration in the development of public policy.

The next paper in this volume was prepared by the Canadian Centre for Philanthropy (CCP). In "Voluntary Health Organizations in Canada: Public Involvement and Support; Results from the 2000 National Survey of Giving, Volunteering and Participating," authors **David Lasby** and **Don Embuldeniya** provide information about Canadians who donate money and volunteer time to voluntary health organizations.

Their paper updates a previous report, *Voluntary Health Organizations in Canada: Public Involvement and Support*, which was based on data from the 1997 National Survey of Giving, Volunteering and Participating (NSGVP). The current paper compares the 2000 and 1997 data to give an indication of trends in giving and volunteering to voluntary health organizations in Canada.

In terms of giving, both the percentage of Canadians who gave to health organizations and the average annual health donation increased in every province between 1997 and 2000. While broadly typical of Canadians as a whole, health donors were more likely to be well-educated, employed (particularly full-time) and to have higher than average household incomes. They were also more likely than other donors to give because of a personal connection to the work of the organizations they supported. As in 1997, the bulk of the money donated to health organizations came from a relatively small number of Canadians. (The 25 percent of Canadians who donated more than $69 during the year to health organizations accounted for 76 percent of the total value of health donations.) Voluntary health organizations may want to consider how they can broaden this base of support. They may also want to re-examine the ways in which they solicit donors and address donors in uncertain economic times.

In terms of volunteering, while the percentage of Canadians who volunteered for health organizations declined slightly between 1997 and 2000, health volunteers contributed more hours each on average (87 hours in 2000, up from 73 hours in 1997). Personal connection was a strong motivator for health volunteers. But while the dedication and personal commitment of health volunteers were strong, there are a couple of areas that may be of concern to voluntary health organizations. A relatively small number of health volunteers did most of the work. (The 25 percent of Canadians who volunteered 72 hours or more annually to health organizations accounted for 85 percent of the total number of volunteer hours.) Health volunteers, like other volunteers, are increasingly time-stressed, and health organizations may need to restructure their volunteer opportunities to accommodate volunteers who have only a limited amount of time to give.

The authors note that health donors and volunteers play an important role in financing and delivering health programs and services. Any reduction in their number could have a serious impact on health organizations. The impact could be particularly significant at a time when governments are considering changes to the financing of the health sector in Canada and reliance on voluntary effort is likely to grow.

The fourth paper in Volume 2 is an earlier study, which was also prepared by the Canadian Centre for Philanthropy. "Charitable Giving to Charitable and Non-Profit Health Organizations: Perspectives Provided from the (1997) National Survey of Giving, Volunteering and Participating," by **Angela Febbraro** and **Michael Hall**, has two main objectives. First, it assesses the implications of the 1997 NSGVP classification of health organizations for interpreting survey findings given the definition of health used by Health Canada and elaborated by the Joint Working Group on the Voluntary Sector (1999). Second, it provides an analysis of the 1997 NSGVP data on giving to voluntary health organizations and illustrates how the present classification system can be employed to derive information about charitable giving to health organizations. The authors note that despite some limitations, the classification of organizations employed in the 1997 NSGVP allows for insight into the extent and nature of public support for organizations that are perceived to be working directly on health issues, consistent with the Health Canada framework.

These four papers make up *Voluntary Health Sector Working Papers (Volume 2)*.

# Volunteers Are Not All The Same: The Case of Health Organizations

**Prepared for Health Canada as one in a series of reports from the Nonprofit Sector Knowledge Base Project.**

**Statistics Canada and Carleton University**
**Paul B. Reed and L. Kevin Selbee**

**2002**

The authors welcome comments and suggestions. Paul Reed can be reached at:

Telephone: (613) 951-8217
Facsimile: (613) 951-6313
e-mail: paul.reed@statcan.ca

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# Table of Contents

**Introduction** ..... 4

**Research on Heterogeneity in the Voluntary Sector** ..... 7

**Data and Analysis Strategy** ..... 8

**Analysis Results** ..... 12

**Social Dynamics: The How and Why of Being a Volunteer** ..... 16

**Concluding Discussion** ..... 19

**Implications for Further Inquiry** ..... 21

**Appendix: List of Variables** ..... 22

**References** ..... 25

# Volunteers Are Not All the Same: The Case of Health Organizations

## Introduction

Sorting processes are ubiquitous in human affairs; certain kinds of people are more likely to select certain fields of work than others, or to live in certain kinds of neighbourhoods, to engage in certain types of activities or have affiliations with particular kinds of organizations. One of the broad purposes of social science is to map and understand sorting processes in diverse domains. The field of voluntary action is one where there has been little consideration of sorting processes and so there is not yet a robust answer to the question, are certain kinds of individuals (i.e., having distinctive combinations of traits) more likely to volunteer for certain types of voluntary organizations than are other kinds of people?

This study compares individuals who volunteer for health organizations with those who volunteer for culture and recreation, social service, and religious organizations. Three questions directed our inquiry. Do health volunteers differ from volunteers for other kinds of organizations. If so, in terms of what traits do health volunteers differ?* And, what characteristics do health volunteers have in common with each other? Answers to these questions will enhance our understanding of the voluntary sector as a whole, and could also provide health organizations with information about the socio-demographic characteristics and social dynamics associated with health organization volunteers, thereby identifying components of the population they currently do not draw volunteers from and enabling them to adapt their recruitment strategies to tap such resources.

This analysis lies on uncharted terrain: there is little research on the interesting questions of who volunteers for what and why. Even a brief review of the literature reveals a considerable number of studies of who volunteers but even so, there are still a substantial number of inconsistent, even contradictory, findings. A systematic picture of who volunteers and why is beginning to emerge but remains far from complete (Wilson, 2000; Smith, 1994).

This is due in part to the fact that research on who volunteers typically treats all volunteers as a single homogeneous group. As a consequence, it tries to account for a "vast array of disparate activities" with one theoretical perspective (Wilson, 2000: 233; see also Williams and Ortega, 1986:35 and Cnaan and Amrofell, 1994: 338). In some measure, this is the result of there not being a useful theoretical or practical taxonomy of volunteer activity, which in turn is due to the lack of a compelling theory of volunteer behaviour in general.

Some authors have attempted to develop conceptual schemes for classifying the activities and organizations people volunteer for. One of the earliest of these divides organizations into distinct groups according to the function they fulfill for their members. Gordon and

* This report is adapted from a more general study, "Volunteers Are Not All The Same: An Examination of Heterogeneity in Canada's Voluntary Sector". Ottawa: Statistics Canada, 2002.

Babchuck introduced the distinction between expressive and instrumental organizations in 1959. Expressive organizations provide activities mainly for their members as an end in themselves, while instrumental organizations function as social influence organizations that create or maintain some normative condition or change (1959:25). The immediate problem with this classification, as the authors themselves acknowledged, is that the two categories are not mutually exclusive: some organizations clearly fulfill both functions and so constitute a third category, instrumental-expressive organizations (1959:26). This three-fold scheme has appeared regularly, if sparsely, in the research literature since it first appeared (see Tomeh, 1973; McPherson and Smith-Lovin, 1986; Palisi and Korn, 1989; and Caputo, 1997, for discussion and application of this classification).

Over the years since, various related classifications have been proposed. Smith (1997: 273-274) makes a distinction between mutual benefit organizations, where members are the primary beneficiaries of their voluntary activity, and organizations where the beneficiaries lie outside the membership. This is linked to his discussion of association volunteers, who work to maintain an organization, and program volunteers, who work for the external clients of an organization. Janoski and Wilson (1995: 272) distinguish between self-oriented associations (professional and union groups) and community-oriented associations (community volunteers, church groups, etc.). And as their application of this distinction shows, a different theoretical model is required to adequately explain each type of volunteer activity (1995:289-290).

Another axis of differentiation in volunteer activities that often arises in research in this area is the difference between volunteering for secular and for religious organizations. This distinction typically appears in ad hoc fashion, as when an analysis attempts to understand the role of religious affiliation and religious beliefs in the motivation to volunteer (see Cnaan et al., 1993; Musick et al., 2000). The usual approach here is to examine how the individual's religious beliefs and practices, such as church attendance, affect the chances of volunteering for religious organizations as compared to secular organizations.

Last, there is another approach to the issue of heterogeneity in volunteer activities that begins without a clearly delineated theoretical classification of activities or organizations, but instead simply uses the types of groupings of organizations that are typically found in survey data and looks for differences between volunteers for the various types of organizations. In such cases, the argument is usually made that various types of organizations reflect important if not well-defined dimensions of differentiation between volunteers in terms of their personal characteristics, values and motivations. In one of the few studies specifically designed to address the question of multidimensionality in volunteer activities, Williams and Ortega (1986) explicitly follow this strategy. Others have looked at the factors that influence joining a specific type (or subset of types) of organization (Cnaan etal., 1993; Rotolo, 2000) or have compared those who join a particular type of organization versus all other types of organizations (Berger, 1991).

All of these attempts to differentiate the types of activities and organizations in which volunteers take part have theoretical value and merit further refinement. One of the main difficulties in trying to apply any of these classifications is that often the level of detail about what volunteers actually do for various organizations is not sufficient to make a clear and accurate assignment to different categories of these classifications. Nonetheless, the attempt is worth the effort if it increases our knowledge about differences among types of volunteers and how these are connected to differences among types of organizations. To this end, our research here examines the traits of volunteers in several types of organizations that can be differentiated along two dimensions, one that follows the distinction between religious and secular organizations, and another axis of classification that is similar to the expressive-instrumental and the mutual benefit/program volunteer distinctions. However, our classification rests not on who benefits from the activity (members versus clients), but rather on whether the service or product provided is an amenity or fills a basic human need. For example, organizations in the fields of culture, arts and recreation typically provide amenities. These may enhance the overall quality of life for a few or many individuals in a society, but it can be argued that given a set of normative and political standards, they are not essential and they are substitutable. In theory, other activities or products could fill the same role in society. If a symphony orchestra or snowmobile club or peewee soccer league ceases to exist, no one would be fundamentally disadvantaged; there are other activities, many not dependent on volunteer inputs, which could provide the same general type of benefit. The fulfillment of human needs, however, is generally not substitutable. Food, clothing, shelter, health care and education are needs that cannot be met by other than these specific services.

The distinction between amenities and need is not the same as the distinction between mutual benefit and program volunteering. In particular, program volunteering that serves a clientele is not identical to fulfilling needs. It may simply be providing an amenity. Many recreation organizations with paid organizational staff depend on volunteers in the delivery of their service. In contrast, some mutual-benefit organizations expend much effort providing for specific needs in their communities. Self-help health groups and low-income housing cooperatives would fall into this category.

The distinctions between amenity and need, and between secular and religious activities, are but two of numerous possible dimensions of differentiation in volunteer activities. These are not discrete categories in clear binary sets; instead, each represents one defining polarity of a continuum along which volunteer activities can be located. The distinction between activities providing for amenities and those providing for needs is a matter of degree, not absolute difference. In assigning organization types to either pole of one or the other of these dimensions, we are proposing that the large proportion of activities in question are of that particular type. The extent to which these dimensions reflect observable differences in the traits, values and motives of volunteers lends credence to the idea that they are important in some way.

## Research on Heterogeneity in the Voluntary Sector

We noted earlier the prevalent but implicit presumption in the field that volunteers are a homogeneous group. This is both antecedent and consequence of there being little systematic research on how people who volunteer for various organizational types differ.

Where organization type is part of the analysis, often the focus of research is on patterns of joining voluntary associations rather than on actually doing volunteer work for such organizations. But since members are often the pool from which volunteers are drawn, research on differential joining can provide useful clues to the factors that might differentiate those who volunteer for different types of organizations.

Overall, the evidence is not comprehensive in terms of the possible correlates that have actually been examined and the results are equivocal at best. Gender provides a prime example. Early research typically found evidence that women tend to volunteer for expressive organizations, while men volunteer for instrumental organization (Babchuk and Booth, 1969). Yet more recent evidence does not support this contention. Williams and Ortega find no difference between men and women in joining recreation (expressive) and civic/political (instrumental) associations (1986:39, Table 1). Palisi and Korn find that women do indeed tend to join expressive organizations more than men, but do not find support for the corollary — women are as likely to join instrumental organizations as are men (1987:187, Table 2). As McPherson and Smith-Lovin point out, as women enter the labour force and traditional gender roles become less distinct, the dichotomy may become less significant (1986:62).

Age is another factor associated with volunteering for some types of organizations but not for others. In particular, participation in church, fraternal/service club and civic/political organizations increases with age, while participation in recreational or job-related organizations does not (Williams and Ortega, 1986:38). Others find that in general, participation increases with age for expressive organizations but is not associated with participation in instrumental organizations (Palisi and Korn, 1989:187). Having children living at home increases participation for child- and youth-related volunteer groups but not for church or job-related groups (Rotolo, 2000:1148). In broader terms, Janoski and Wilson found that human capital factors (education, income, parental socio-economic status) predicted participation in job-related organizations while family socialization factors (parental volunteering, respondent youth activities) predicted participation in community-oriented organizations (1995:289). Taken together, these findings do not produce clear evidence for the utility of the expressive-instrumental dichotomy, but it may be the inadequacy of the broad organizational groups for operationalizing this distinction that is at fault.

The evidence for the secular-religious distinction is not much more consistent. Factors such as being married and having children in the household have been shown to increase participation in religious organizations (Rotolo, 2000:1148). And not unexpectedly, factors associated with religious commitment have a positive effect on volunteering for religious but

not for secular organizations. Religiosity increases participation in church-related but not in secular human service organizations (Cnaan, etal., 1993:47). However, religious commitment can also have a negative effect on some types of volunteering. High levels of church attendance can actually displace participation in secular organizations by maximizing participation in religious or mixed religious secular organizations (Musick etal., 2000:1559).

To date, research on the importance of the context in which individuals volunteer is far from conclusive. It does suggest, nonetheless, that our understanding of who volunteers and why would be improved by a consideration of the types of organizations in which individuals of what kinds participate.

## Data and Analysis Strategy

Our analysis uses data from the Statistics Canada 2000 National Survey of Giving, Volunteering and Participating (NSGVP). The data file consisted of completed cases from 14,724 respondents, containing 44 variables which are listed in the Appendix. The dependent variable throughout is formal volunteering defined as unpaid work for a formal nonprofit organization. In the NSGVP 2000, 26.7 percent of respondents reported having done formal volunteering during the preceding 12 months.

The first task was to determine the procedure for identifying individuals who volunteered for each of the four types of organizations we wanted to examine: health, culture and recreation, social services, and religious. We used the two-digit level of the International Classification of Non-Profit Organizations (ICNPO) developed at Johns Hopkins University. This classification scheme assigns nonprofit organizations to 12 broad groups on the basis of each organization's principal activity or field of work (Salamon and Anheier, 1996). Assignment of volunteers' organizations in the NSGVP to this classification was made by a panel of experts associated with the survey at Statistics Canada.

All organizations cited by NSGVP respondents were distributed among the 12 categories as shown in Table 1. Some organization types which contained too few cases to be statistically usable, such as environment, were eliminated from the analysis. Several other classes of organizations were eliminated (e.g., business and professional associations and unions) because the nature of their principal activity or purpose was difficult to compare with the major ones.

**Table 1**

Table 1: Distribution Across ICNPO Categories of Organizations Volunteered For[1]

| ICNPO Category | Number of Organizations Reported | Percent of Organizations Reported |
|---|---|---|
| Culture and recreation | 1420 | 23.2 |
| Education and Research | 800 | 13.1 |
| Health | 768 | 12.5 |
| Social Services | 1200 | 19.6 |
| Environment | 170 | 2.8 |
| Development and Housing | 303 | 5.0 |
| Law, Advocacy, and Politics | 198 | 3.2 |
| Philanthropic Intermediaries and Volunteer Promotion | 136 | 2.2 |
| International | 52 | 0.9 |
| Religion | 872 | 14.2 |
| Business and Professional Associations, and Unions | 139 | 2.3 |
| Not Elsewhere Classified | 66 | 1.1 |
| Total Organizations Volunteered For | 6124 | 100 |

1. Because each respondent could report affiliation with up to three organizations, any or all of which could fall in the same ICNPO category, this table displays the distribution of organizations reported on, not the distribution of respondents across the organizations they volunteered for. The total number of volunteers in the sample is 3,633, while the total number of organizations they reported volunteering for is 6,124.

In the end we selected four categories: health, culture and recreation, social services, and religion. A partial list of the types or organizations in each group is given in Table 2. For the first three major categories, the types of organizations they encompass are fairly straightforward. Health organizations include those associated with hospitals and rehabilitation, nursing homes, mental health and crisis intervention, and other services such as public health and emergency services. Culture and recreation includes groups that foster and support culture and the arts, sports, and recreation and social clubs. Social service organizations are those involved with child, youth and family services, services for the handicapped and the elderly, emergency and relief services, and income and literacy assistance. The fourth category, religion, covers associations and auxiliaries of religious congregations that promote religious beliefs and administer religious services. This category does not include religion-based organizations whose primary function is to address needs in other fields, such as social services. Thus the Salvation Army and Saint Vincent de Paul Society, for example, are assigned to the social service major group rather than the religion category.

**Table 2**

Table 2: Examples of Organizations, in Four Categories of the ICNPO Classification (Used in this Analysis)

| ICNPO Major Group | | | |
|---|---|---|---|
| Health | Culture and Recreation | Social Services | Religion |
| Arthritis Society | Minor sports | Big Brothers/Sisters | Church |
| Cancer Society | Kinsmen club | Scouts/Guides | Mosque |
| Heart Foundation | Knights of Columbus | Meals on Wheels | Temple |
| Kidney Foundation | Lions club | Red Cross | |
| St John's Ambulance | Optimists | Salvation Army | |

The method of assigning organizations to the ICNPO categories leaves some ambiguity as to the essential nature of, and activities undertaken by, the organizations in each group. Without a complete list of all the organizations assigned to each major group, and in the absence of detail about specific activities undertaken by a respondent's organization, there is less than full certainty as to what the ICNPO groups actually represent in terms of the behaviour of volunteers. In order to minimize that uncertainty while still retaining enough cases to achieve reasonably generalizable results, we restricted our comparison to the above-mentioned four largest categories of organization. The one large category we excluded from the analysis was that of education and research (13.1%) because it contains considerable heterogeneity, not only teaching and research but also activity under the label 'schools and school boards'.

The remaining ICNPO categories excluded from the analysis are much smaller proportions of the total set of organizations volunteered for and they were excluded because of their size. These include development and housing (5%), law, advocacy and politics (3%), environment (3%), business or professional associations and unions (2%), philanthropic promotion (2%), international organizations (1%), and not classified (1%).

We focused our analysis on the four selected organization types in order to distinguish as clearly as possible between at least three main types of activity (amenity, need and religion). In practice, the distinction is not made so easily, since each volunteer can be involved in a number of organizations and reported on up to three in the survey. In order to maintain the purity of the four types, we excluded any respondent who had volunteered for more than one of the four organization types, which amounted to 10 percent of all volunteers. As a result, there is no overlap in our data among the four groups; if a respondent volunteered for one type, then he or she was not associated with any of the three other types. However, we did

allow volunteers in each of the main groups to also be volunteers for any of the other eight excluded groups. This decision reduced the purity of the distinction made between the four main categories, but only by a negligible amount. This was confirmed in a sensitivity test, comparing the trait profile of the pure and mixed versions. They were virtually identical. The size of each of the resulting groups is presented in Table 3.

**Table 3**

Table 3: Distribution of Respondents Across Organization Types

| | Count | Percent of Sample | Percent of Volunteers in the sample | Percent of volunteers in the analysis |
|---|---|---|---|---|
| Non-Volunteers | 10791 | 73.3 | | |
| Volunteers for : | | | | |
| Health organizations | 386 | 2.6 | 9.8 | 15.8 |
| Culture and Recreation organizations | 854 | 5.8 | 21.7 | 35.0 |
| Social Service organizations | 684 | 4.6 | 17.4 | 28.0 |
| Religious organizations | 518 | 3.5 | 13.2 | 21.2 |
| Sub-Total | 2442 | 16.5 | 62.1 | 100 |
| A combination of the above, or other organizations[1] | 1491 | 10.1 | 37.9 | |
| Total | 14724 | 100 | 100 | |

1. These cases are excluded from the analysis because they (1) were people who volunteered for a health organization and one or more of culture-recreation, social service, or religion organizations, or (2) were people who did not volunteer for any of these four organization types.

## Analysis Strategy

Our analysis was undertaken in four successive steps. We first compared health volunteers with all non-volunteers in the sample; in the second stage, health volunteers were compared with volunteers in all three of the non-health groups combined; third, the health volunteer group was compared with each of the culture and recreation, social service, and religious volunteer groups individually. Comparisons were made in pair-wise form for every one of

37 variables in stage 1 and 44 variables in stages 2 and 3. For every comparison, the level of statistical significance of Cramer's V was computed as the basis for determining whether the groups being compared were different; we adopted a significance level of 5 percent as the threshold for identifying a variable as differentiating the two groups. The fourth step produced, via logistic regressions, profiles of distinctive traits of health volunteers relative to volunteers in the other three categories.* This provided a direct test of whether or not health volunteers are unique in some way. The advantage of the logistic analysis is that the independent variables identified by the procedure as significant are those that are important in distinguishing between the two groups of volunteers in question. They are a direct measure of how health volunteers differ from (or are the same as) the other types of volunteers.

## Analysis Results

A. Health Volunteers Compared with Non-Volunteers

Across 37 variables, health volunteers were significantly different on 30 variables. The principal differences can be summarized as follows: health volunteers are more likely than non-volunteers to be:

- a charitable donor, and in the core group of charitable givers who account for two-thirds of total giving
- in the core group for civic participation
- engaged in direct personal helping of others
- individuals who give money directly to others
- residents of the Atlantic, Ontario, and Prairie regions
- in the middle age range (35-64)
- in households with children 6-17
- female
- from the upper range of household income (above $100K)
- from higher categories of education and occupational status
- Protestant
- more religious and more frequent church attenders
- of British or Other ethnic background
- in better health (self-reported)
- more active voters
- more satisfied with and in control of their lives
- more involved during their youth in sports, school and religious groups, and volunteering.

* The extreme ratio of health volunteers (N=383) to non-volunteers (N=10,791) prevented the performing of a reliable logistic analysis. The bivariate analysis results suggest that the pattern of differences we found in another study comparing all active volunteers to non-volunteers is relevant for health volunteers as a subgroup (Reed and Selbee, 2000).

In sum, health volunteers are about as different as, and different in much the same ways from, non-volunteers, as volunteers as a whole are different from non-volunteers. Expressed another way, health volunteers are very typical in their differentness from non-volunteers.

B. Health Volunteers Compared with the Three Other Types Combined

Volunteers associated with health organizations differed from those in culture and recreation, social service, and religious organizations on 15 of 46 variables.

Health volunteers had elevated probabilities of:

- being residents of Ontario
- living in cities of 1 million or larger
- having fewer children age 6-12 in the household
- being female (64% vs. 49%)
- being Protestant

and lower probabilities of

- being in the volunteering core
- being religious and attending church frequently.

Their average annual hours volunteered (111.3) was markedly below the level for the combined group (150.8), as was their average annual charitable giving ($286 vs. $381). A higher proportion of their charitable giving was secular (75%, vs. 65%).

We can conclude, then, that health volunteers are only moderately different from the three other types treated as a single whole.

C(i). Health Volunteers Compared with Culture and Recreation Volunteers

- manifest differences on 19 of 46 variables
- are much more likely to be female
- are less likely to have children at home; to be in the labour force; to live in Quebec or the Prairies; to be involved in social and civic participation; and
- are more likely to be Protestant and to attend church more often.

Volunteers for health organizations contributed an annual average of 111 hours, culture and recreation volunteers 157 hours.

C(ii). Health Volunteers Compared with Social Service Volunteers

- differed on only 8 of 46 variables
- were more likely to be female and to be married
- were a little more likely to be of British ethnic background
- were a little more likely to be older (younger ages were slightly and relatively more prevalent among culture and recreation volunteers).

Health volunteers, then, differed little and on few variables, from their counterparts in social service organizations.

C(iii). Health Volunteers vs. Religious Organization Volunteers

Differences existed for 17 of 46 variables. Health volunteers were more likely to live in large cities, to have smaller families, to be Catholic or 'no religion', to be Canadian-born and of British ethnic background, to be in the middle age range, and less likely to attend church often and to be in the core group for charitable giving and civic participation.

Health volunteers and religious volunteers did not differ in total annual time volunteered but differed very significantly in their giving behaviour: health volunteers contributed one-third the annual amount of religious volunteers ($286 vs. $796), with a much greater proportion of it going to secular organizations (75% vs. 40%).

D. Identifying the Distinctive Characteristics of Health Volunteers: From Bivariate to Multivariate Analysis

Contributory behaviours such as volunteering and charitable giving are known to be complex, multi-dimensional phenomena that are not always captured fully and effectively by simple bivariate analysis, even when done in many increments. This prompted us to estimate four logistic regression models to provide a more holistic, multivariate portrait of the distinguishing traits of health volunteers. As in Section C, health volunteers were examined in four comparisons: with culture-recreation, social services, and religious organization volunteers all combined, and then with each of these three types individually. A summary of the results is presented in Table 4 and we comment here on the content of these four models.

## Table 4

Table 4: Summary of Significant Variables in the Logistic Regression Models1

| Model 1<br>Health vs. Three Groups | Model 2<br>Health vs. Culture-Rec | Model 3<br>Health vs. Social Service | Model 4<br>Health vs. Religion |
|---|---|---|---|
| - Hours volunteered annually | - Hours volunteered annually | - Hours volunteered annually | |
| + % of giving that is secular | | | + % of giving that is secular |
| - Church attendance | + Church attendance | | - Church attendance |
| Religion (vs. No Religion) | | | Religion (vs. No Religion) |
| + Catholic | | | + Catholic |
| | | | - Other |
| + Resides in CMA | + Resides in CMA | | |
| Region (vs. Ontario) | Region (vs. Ontario) | Region (vs. Ontario) | |
| + Quebec | - Quebec | - Quebec | |
| + Prairies | - Prairies | | |
| + Female | + Female | | |
| - Canvassed as a youth | - Canvassed as a youth | - Canvassed as a youth | |
| + Student gov't as a youth | | + Student gov't as a youth | |
| | - Years resident | | |
| | | Age (vs. 15-24) | |
| | | + 55-64 | |
| | | Family income (vs. 100,00+) | |
| | | + 60-100K | |
| | - Children 6-12 | | |
| | + # informal helping types | | |
| | + Total charitable giving ($) | | |
| | - Civic participation | | |
| | - Social Participation | | |
| | | | - Religious group as a youth |
| | | | - Religiosity |
| $X^2$ 108.9 | 184.7 | 53.8 | 356.4 |
| df 10 | 13 | 6 | 6 |
| pseudo-$R^2$ 5% | 21% | 7% | 46% |

1 Only effects significant at the 0.05 alpha level or better are displayed. Variables preceded by a minus sign have a negative effect on the probability of being a Health volunteer, those preceded by a plus sign have a positive effect

Model 1, a comparison of health volunteers with those in all of the other three types, has a very low level of explained variation ($R^2$): 5 percent. This indicates the combined group of three types is relatively heterogeneous and overlaps considerably with the health group's traits. This suggests it is inappropriate to group the three types together because of the considerable heterogeneity among them.

Model 2, health compared with culture-recreation volunteers, has the largest number of significantly differentiating traits (12) of the three non-health types. In socio-demographic terms, health volunteers are most different from culture and recreation volunteers (relative to social service or religious volunteers). The moderate level of 21 percent of variance explained suggests there are yet more unmeasured dimensions, possibly nonsocio-demographic.

Model 3, health versus social service organization volunteers, contains only six significant variables but they do not present a coherent or systematic picture of the differences, explaining only 7 percent of total variance. This indicates that health and social service organizations are not systematically different, at least in their socio-demographic traits. If they differ, it is on other unmeasured factors.

Model 4 contains five significant variables and all relate to religion and religiosity. $R^2$ is a high 46 percent, suggesting that the principal difference between health and religious volunteers arises from the secular/religious aspect of the organizations they work for. For practical purposes, these two types of volunteers are effectively identical on all other characteristics.

## Social Dynamics: The How and Why of Being a Volunteer

The sorting processes that link individuals with different socio-demographic characteristics to different types of organizations work in part through their effects on the values volunteers hold, the reasons that prompt them to volunteer, and the events through which they actually become volunteers. Along with the effects of socio-demographic and life cycle factors, these more immediate aspects of personal experience and events together constitute the social dynamic that underlies volunteering of one kind or another. In this section we examine how the four organization types compare on the personal experience component of these dynamics. Text commentary is based on figures in Tables 5 and 6. We have reserved analysis of these characteristics of volunteers until now because preliminary statistical analysis found that they mask the effects of the socio-demographic variables we have discussed to this point. The values of volunteers, the specific reasons they volunteer and the events through which they began as volunteers have stronger and more visible effects on volunteering because of their greater immediacy, relative to socio-demographic variables. In many cases, the more diffuse effects of socio-demographic factors are mediated by these intervening variables. This does not mean that socio-demographic traits are less influential, only that part of their effect on volunteering is indirect — it is through their effect on values, reasons and how individuals actually come to be volunteers.

There were two sets of variables in our data that captured aspects of volunteers' values and reasons; these were reasons for volunteering and reasons for not volunteering more. The way individuals begin volunteering distinguishes between whether they were asked to volunteer or started on their own initiative.

**Table 5**

Table 5: Reasons for Being a Volunteer[1]

| Reason for being a volunteer | Health | Culture-Recreation | Social Services | Religion |
|---|---|---|---|---|
| | Percent who agree[2] | | | |
| Personal cause | 94 | 94 | 95 | 96 |
| Personally affected | 74 | 70 | 68* | 72 |
| Friends volunteer | 24 | 35* | 29 | 27 |
| Job opportunities | 21 | 22 | 25 | 15* |
| Religious beliefs | 15 | 12 | 17 | 73* |
| Explore own strengths | 50 | 55 | 58* | 65* |
| Use skills and experience | 68 | 86* | 81* | 81* |
| Required by school etc. | 9 | 6* | 9 | 7 |

1. * Comparison to Health volunteers is significantly different at alpha= 0.05

2. Percentages round to nearest whole number.

For the most part, health volunteers give the same reasons for volunteering as do volunteers for culture and recreation, social service, and religious organization volunteers, but there are some intriguing differences. Health volunteers are markedly less likely to give self-oriented reasons for volunteering ('exploring one's strengths' or 'using one's skills') than are the three other types. Along similar lines, they are also less likely to volunteer because their friends do compared with culture and recreation volunteers, and are slightly more likely to volunteer because they have been personally affected than are social service volunteers. And not surprisingly, they are substantially less likely to volunteer because of religious belief than are religious group volunteers. Again, this brings out the secular-religious distinction between health and religion volunteers.

When asked why they do not volunteer more of their time, health volunteers give the same reasons as do social service and religion volunteers, except that they are more likely to say they have no extra time or that they give money instead of more time, than do social service volunteers. Compared with culture and recreation volunteers, however, health volunteers are more likely to say they have a health problem or that they give money instead of time, and are less likely to say they feel they have already made their contribution, that they fear being sued, or that they simply have no interest in doing more. Those last three response categories

in particular reinforce the conclusion that health volunteers are somewhat more other-oriented, especially in comparison to culture and recreation volunteers.

**Table 6**

Table 6: Reasons for Not Volunteering More[1]

| Reason for not volunteering more | Health | Culture-Recreation | Social Services | Religion |
|---|---|---|---|---|
| | Percent who agree[2] | | | |
| Have already made a contribution | 28 | 34 * | 25 | 28 |
| Have no extra time | 76 | 78 | 68 * | 76 |
| Have health problems | 18 | 14 * | 16 | 21 |
| No one asked | 18 | 16 | 16 | 15 |
| Don't know how to connect | 8 | 8 | 10 | 10 |
| Cost of volunteering | 11 | 13 | 14 | 12 |
| Fear being sued | 3 | 8 * | 5 | 5 |
| No interest | 13 | 19 * | 13 | 16 |
| Give money instead | 29 | 22 * | 23 * | 30 |
| Unwilling to commit | 38 | 33 | 32 | 34 |
| Disaffected with prior experience | 7 | 9 | 7 | 8 |

1. * Comparison to Health volunteers is significantly different at alpha= 0.05

2. Percentages round to nearest whole number.

Health volunteers overall are less likely to begin volunteering because of their children or because they are members of an organization. They are slightly more likely to have begun volunteering due to having been asked by either an organization or friends than are the other volunteer types. However, they are substantially more likely to have begun volunteering on their own initiative than are either culture and recreation or religion volunteers.

We also examined two other aspects of the social dynamics of volunteering that reflect characteristics of the experience itself: the length of time people had been volunteers, and the kinds of tasks or activities they undertook as volunteers. Health volunteers had been involved in volunteering for an average of four years, about the same as social service volunteers (4.1 years). This is less than culture and recreation volunteers (5.4 years) but not by a large margin, and is considerably less than religion volunteers (6.7 years). The lower length of service for health and social service volunteers may be due in part to a higher turnover rate for these types. It may also be due to the unanticipated experience of illness around them, which could prompt a more episodic involvement in health-related volunteering. Since volunteers of these kinds often deal with people in crisis or in chronic care, a higher turnover may reflect the greater likelihood of volunteer illness or burnout.

The tasks volunteers undertake in any organization — fundraising, serving on a board or committee, organizing activities, teaching/coaching, visiting people, driving, doing maintenance, and counselling are examples — will reflect in part the organization's needs and its structure, particularly the distribution of responsibilities between paid staff and volunteer workers. But, it will also reflect the volunteer's abilities and preferences in some measure as well. Unfortunately, our data do not contain information about why each volunteer performed the functions he or she did. In the overall distribution of tasks, health volunteers did not differ much from other volunteer types. On only four of the fifteen task types do health volunteers consistently stand out from the other types: they are more likely to be involved in fundraising and hospital/nursing home visits, and less likely to be involved in organizing activities or building maintenance.

In all these proximate aspects of the social dynamics of volunteering, health volunteers are different from other kinds of volunteers in some ways and quite similar in others. Health volunteers appear to be less self-oriented in their volunteering and more willing to help on their own initiative particularly as compared to culture and recreation volunteers. Many are volunteers for shorter periods of time, and are not very different in the tasks they perform as volunteers.

## Concluding Discussion

The series of analyses comprising this study proffer answers to the three guiding questions. We now know that health volunteers differ primarily and significantly from volunteers for culture and recreation organizations (differences on 19 of 46 traits). Health volunteers are relatively less engaged in varied forms of contributory and community activities, are more frequent church attenders, are more likely to be female and not in the labour force, and volunteer only about two-thirds as much time each year. On the other hand, health volunteers differed hardly at all from social service volunteers (differences on only 18 of 46 variables). They are, in socio-demographic terms, essentially the same kind of people. (Health volunteers were a little more likely, in relative terms, to be married, female, older, and of British extraction.) Given the strong similarities between providing health services and providing social services, this naturally makes sense. Health volunteers also manifested considerable similarity to volunteers for religious organizations, showing no differences on 29 of 46 variables; many of the 17 variables-of-difference pertained to religious characteristics, permitting us to say that by and large health volunteers are the secular version of religious organization volunteers (and vice versa). The principal and very clear fault line runs between culture and recreation volunteers on one side and health, social service, and religious organization volunteers on the other. This fault line is easily understood in terms of the presence of a leisure activity aspect in culture and recreation organizations, and the strong element of ideals and principles associated with the health/social service/religious constellation of volunteering. This is evidently a dimension of differentiation that requires deeper exploration.

As for the distinctive traits of health volunteers relative to other volunteer types, our logistic regression models uncovered approximately 10, namely that health volunteers

- contribute about one-third fewer hours annually
- attend church more than culture and recreation volunteers
- are more likely to be Roman Catholic
- live in greater numbers in metropolitan Ontario
- are female
- were less involved in volunteering in their youth than other types
- are in their later middle years (55-64)
- are in high income categories ($80K+)
- have fewer young children in the household
- are less involved in general civic activities.

In sum, health volunteers do stand out from other types but not in sharp relief; they differ mainly from only one of the three comparison groups, and they do not manifest a high-contrast set of shared characteristics.

The analysis has revealed, further, that the voluntary sector can be considered textured or "grainy" in terms of the distribution of volunteer traits; it is neither seamless, nor extremely "lumpy". Rather than an undifferentiated population of volunteers or discrete, largely mutually different groupings or types of volunteers, the pattern is one of overlapping sets of similarities separated by blocks of differences of varying size, in a patchwork. For some purposes, those differences are of small importance while for other purposes, they are of signal importance.

It is clear from the patterns we have identified that there are both strongly deterministic, and a mixture of weakly deterministic or random, social processes producing the clusters of similarities and differences. Religious organization volunteers, for example, are the product of powerful forces of family background and early life experiences related to religious practice, but not of life cycle stage (or of some numerous socio-demographic traits), while the reverse of this holds true for the other three volunteer types. And it is early life cycle stage (under age 35) adults who are more involved as culture and recreation volunteers, and later life cycle stage people who are involved as health volunteers, i.e., when the contingencies of family and career have diminished.

All of our generalizations are limited to the four categories of volunteer organization this analysis focused on but can be broadened with a larger volume of data pertaining to more purely-defined categories of volunteer organizations such as those for education, environment, housing, law/advocacy/politics, and international service.

## Implications for Further Inquiry

This study has illuminated the social sorting processes of volunteer types. It advances our understanding of the axes or dimensions of similarity and difference that run through the voluntary sector. As well, it points to further inquiry in several directions. One is the social ethos of different types of volunteers: do health volunteers, for example, embrace a set of values and beliefs (or even just one or two prime values and beliefs) that differ from those of other volunteer types? Another is the need to understand the nature of the social logic or reasoning volunteers of various kinds use when making decisions — to begin volunteering, to continue volunteering, in selecting an organization and choosing which tasks to perform — in order to better understand the social sorting processes that lead particular kinds of individuals to be volunteers of particular kinds. This also bears on the link between formal volunteering and direct, personal helping and caring: many health volunteers do both, and there is value in knowing in extended detail how "health-carers" think about the connection between these two modes of contributory behaviour. Each of these directions of inquiry can be pursued best and perhaps only via small-sample but high-detail-content studies. They offer potential for the health voluntary sector to better understand and utilize its key resource.

## Appendix: List of Variables

| | Appendix: Variables in the Analysis | |
|---|---|---|
| -- | Is a high hours volunteer (volunteer core) | |
| -- | Is a high level giver (giving core) | |
| -- | Participates in multiple organizations (civic core) | |
| -- | Total Annual Hours Volunteered | |
| -- | Number of types of informal helping | |
| -- | Gives to Formal Charities | |
| -- | Total Amount Donated to formal charities ($) | |
| -- | % of Giving that Goes to Secular Organizations | |
| -- | Gives $ directly to others (informal giving) | |
| -- | Total $ donated (formal and informal) | |
| -- | Civic participation (number of types of organization participation) | |
| -- | Social participation (frequency of socializing with friends and relatives) | |
| -- | Resides in a CMA | |
| -- | Region (relative to Ontario) | |
| | | Atlantic |
| | | Quebec |
| | | Prairies |
| | | B.C. |
| -- | Age (relative 15-24) | |
| | | 25-34 |
| | | 35-44 |
| | | 45-54 |
| | | 55-64 |
| | | 65+ |
| -- | Children 0-5 | |
| -- | Children 6-12 | |
| -- | Children 13-17 | |
| -- | Marital Status (relative to Married) | |
| | | Single |
| | | Separated/Divorced/Widowed |
| -- | Gender (female=1) | |
| -- | Income (relative to 100K +) | |
| | | 0-20K |
| | | 20-40K |
| | | 40-60K |
| | | 60-100K |
| -- | Education in years of schooling | |
| -- | Occupation (relative to Managers) | |

| | | |
|---|---|---|
| | | Professionals |
| | | White Collar |
| | | Blue Collar |
| | | No Occupation |
| -- | Church Attendance, times per year | |
| -- | Religiosity | |
| -- | Religion (relative to No Religion) | |
| | | Catholic |
| | | Protestant |
| | | Other religion |
| -- | Ethnicity (relative to British Background) | |
| | | Canadian |
| | | French |
| | | Other religion |
| -- | Immigrant | |
| -- | Years resident in the Community | |
| -- | Voted in last elections | |
| -- | T.V. Hours per week | |
| -- | Attention to News | |
| -- | Self-reported Health | |
| -- | Satisfaction with Life | |
| -- | Sense of Control over life | |
| -- | Youth experience: Team Sports | |
| -- | Youth experience: Youth Group | |
| -- | Youth experience: Volunteering | |
| -- | Youth experience: Had a Role Model | |
| -- | Youth experience: Canvassing | |
| -- | Youth experience: Was Helped by Others | |
| -- | Youth experience: Student Government | |
| -- | Youth experience: Religious group | |
| -- | Youth experience: Parents were volunteers | |
| | Reasons for Volunteering | |
| -- | | Personal cause |
| -- | | Personally affected |
| -- | | Friends volunteer |
| -- | | Job opportunities |
| -- | | Religious beliefs |
| -- | | Explore own strengths |
| | | Use skills and experience |
| -- | | |

| | |
|---|---|
| | Required by school, employer or government |
| Reasons for not volunteering more | |
| | Have already made a contribution |
| | Have no extra time |
| | Have health problems |
| | No one asked |
| | Don't know how to connect |
| | Cost of volunteering |
| | Fear being sued |
| | No interest |
| | Give money instead |
| | Unwilling to commit |
| | Disaffected with prior experience |
| Tasks done as a volunteer | |
| | Fundraising |
| | Board or committee work |
| | Educate or Influence |
| | Organize activities |
| | Executive or office work |
| | Teach or coach |
| | Counseling or visiting |
| | Provide care at a hospital or old age home |
| | Assist self-help group |
| | Collect or deliver food, clothing, etc. |
| | Building maintenance |
| | Driving |
| | Protecting the environment or wildlife |
| | Other ways |
| Years since became a volunteer | |
| How became a volunteer | Was a member of the organization |
| | Organization asked |
| | Friend or employer asked |
| | Own initiative |
| | Because own child was involved |

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# Health Human Resources: The Role of the Voluntary Sector

**Applied Research and Analysis Directorate**
**Health Canada**

**Jeff Carr**

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# Table of Contents

**Introduction** ..... **30**
**Data** ..... **31**
*NSGVP* ..... 31
*General Social Survey, Cycle 12, 1998 (GSS)* ..... 31
*Labour Force Survey* ..... 31
*Census* ..... 32
**Volunteering** ..... **32**
**Literature Review** ..... **33**

**The Voluntary Health Sector** ..... **35**
**The Paid Health Sector** ..... **36**
**Valuing Volunteer Time** ..... **38**
*Value to Volunteer* ..... 38
*Value to Organization/Society* ..... 39

**Regression Results on Volunteering Decisions** ..... **40**
**Classification of Variables** ..... **40**
*Time* ..... 40
*Knowledge and Ability* ..... 41
*Social Attitudes and Individual Preferences* ..... 41
**The Model and Methodology** ..... **42**
*Sex and Time* ..... 43
**Regression Results** ..... **44**
**Time Variables** ..... **44**
*Marital Status* ..... 44
*Children Aged 0-5* ..... 45
*Labour Force Status* ..... 45
**Knowledge and Ability Variables** ..... **46**
*Age* ..... 46
*Children Aged 6-18* ..... 46
*Education* ..... 46
*Health* ..... 47
*Duration in Community* ..... 47
*Birth Country* ..... 48
**Attitudes and Preferences** ..... **48**
*Sex* ..... 48
*City Size* ..... 48
*Religion and Religious Devotion* ..... 49
*Province* ..... 50
*Income* ..... 50
*Youth Experience* ..... 51
*Year* ..... 51
**Summary of Key Results and Policy Implications** ..... **52**

**Conclusion** ..... **54**

**Appendix I: Formal Volunteering** ..... **56**

**Appendix II: Informal Volunteering** ..... **57**

**Appendix III: Regression by Sex** ..... **58**

**Appendix IV: Regression by Time** ..... **59**

**Appendix V: Independent Variables** ..... **60**

**References** ..... **62**

# Health Human Resources: The Role of the Voluntary Sector

## Introduction

In 1997, the various levels of the Canadian government combined to spend slightly over $51 billion on health care, and private individuals contributed another $22 billion. This money paid for doctors, hospitals, and drugs, among many other things, but it does not represent the total involvement of society in the production of health care services. A great deal of the provision of health care in Canada takes place through the efforts of unpaid volunteers, whether it is in the formal setting of a hospital or the more informal setting of a neighbour's home. In fact, this paper estimates that 2.4 billion hours were volunteered in health in 1997, with the value of this time estimated at $20-30 billion. When one looks at the health care system in Canada in general, and more specifically the role of human resources in that system, it is important to remember that not all of the services provided are those that are bought and paid for. It is particularly important to understand the role of the voluntary sector if the intention of the various governments is to move away from providing health services through formal institutions such as hospitals, where volunteers play a minor role, to communities, where volunteers play a much larger role.

This paper has two clear and distinct purposes. In the first section, the contribution of volunteers to the health care system is identified and valued. In isolation this information would have little value, so a comparison is made to paid health workers. The comparison can only be an imperfect measure of the effort of volunteers, since they undoubtedly perform different tasks than paid workers, and have less specifically developed skills in the health care field. However, volunteers represent an important human resource and are best explored in the context of the other human resources of the health care system. There is an attempt to put a value on the work of health volunteers, a difficult issue because the value the volunteer sees is certainly different than the value from the point of view of society as a whole. This paper does not argue that there is a single right value for this time, but rather a range of possible values that communicates the importance of the voluntary sector to the provision of health in Canada.

The second section of this paper moves to a closer examination of the volunteers themselves, and seeks to distinguish those people who volunteer in health from other volunteers. Statistical regression techniques are employed to examine the factors that weigh in the decision to volunteer and the choice of the number of hours that an individual volunteers. Studies have previously been performed on the decision to volunteer and the choice of how many hours to volunteer, but this study extends previous work in four key ways. First of all, a detailed new data set, the 2000 National Survey of Giving, Volunteering, and Participating (NSGVP) allows us to examine many demographic and social factors not previously examined. Second, health volunteers have never been examined in isolation and very little work has been done to try to distinguish this group of volunteers from other groups. Third, almost all previous work has focused on formal volunteers, those who volunteer through recognized organizations, to the

exclusion of a very important group, particularly in health, the informal volunteers. Informal volunteers are those people who help out their friends, family members, and neighbours with the daily activities of life. This group is a key component in health because these volunteers provide an incredible amount of care that acts as both a complement and a substitute for the formally provided care through provincial governments. This paper extends the work done with formal volunteers in the past to informal volunteers and hopes to establish a comprehensive picture of volunteering, particularly in the provision of health services. Finally, a Heckman two-step procedure is used to estimate hours volunteered while accounting for the selection bias introduced by only observing the hours of those who chose to volunteer. While this procedure is common in work using the paid labour force, and it has been used to estimate wages[1] of those who volunteer, it has rarely, if ever, been used to estimate the hours volunteered, despite the fact that it can provide valuable insight.

One final output of this paper is that it examines health volunteering, an area that has rarely, if ever, been thoroughly studied. As a result, a number of questions are asked but not answered, and some data quality and availability issues are identified. These questions and issues are important in establishing a research agenda for future work in the field.

**Data**

Four different data sources are used in this paper, though wherever possible data from the National Survey of Giving, Volunteering, and Participating (NSGVP) is used.

***NSGVP***

The NSGVP is a survey of approximately 18000 individuals regarding their community activities, focusing on the donation of time and money either formally or informally. The data on formal volunteering is a little more complete, since it not only has data on who volunteers but also on how many hours they volunteer. There is a wealth of data on voluntary activity as well as extensive demographic information on the respondents. To date the survey has been undertaken twice, in 1997 and 2000.

***General Social Survey, Cycle 12, 1998 (GSS)***

Each year Statistics Canada undertakes a survey on social issues. The theme changes from year to year, but the focus is always on a specific social issue. In 1998, the GSS focused on the time use of Canadians. This is the best source of data on the amount of time that is informally volunteered in Canada and is used here for the work on the amount of informal hours volunteered.

***Labour Force Survey***

The Labour force survey is a monthly survey of paid employees in Canada. In this paper, data from it is used for the hours and wages of paid employees.

[1] Devlin 2000.

***Census***

The Census is a survey of the Canadian population that is undertaken every five years. The 1996 Census is used here for information on paid health workers as well as information on the hours of informal volunteers.

A few general points concerning the data are in order. First of all, the quality of the data is fairly good with large sample sizes and, with all but the NSGVP, a long history of collecting and interpreting the data. The newness of the NSGVP, particularly the 2000 data that was just released, could present data problems. The original 1997 data had a few problems that were corrected with a subsequent release; hopefully, any kinks with the survey were ironed out through that process. The real data concern is that all of the sources used are surveys and hence subject to biased or erroneous responses. With an area such as volunteering that is not well defined, the potential for respondent error is higher. Also, it looks better to have volunteered, so all the incentives lean toward an overstating of voluntary activity, particularly in hard to define areas such as informal volunteering, if bias was to be found. Having said that, sample sizes were large and from Statistics Canada, which has a strong reputation and a long history of data collection.

The NSGVP is quite a comprehensive survey in general but two key elements are missing. Most importantly, no data on informally volunteered hours was collected despite this being the perfect vehicle to collect this data. This forces the use of other surveys to estimate these hours, which raises compatibility issues and makes the results less robust to criticism. The second area that is missing is good data on the reasons why individuals volunteer. Respondents are asked about their motivations but the questions are very broad and don't address key issues, such as whether the individual was asked to volunteer in the previous year. The other key omission in this study is physicians, who are excluded from the labour force survey because they do not earn a wage; they are generally paid on a fee-for-service basis.

The final data issue is the compatibility of the various data sources. The main compatibility problem arises from the need to go outside the main data source for key information – informally volunteered hours. The surveys used to estimate this information were from different years, obviously surveyed different people, and asked a different group of questions. While the large size of the data sets lends credibility to the results, applying the average number of informal hours to a different data set is an imprecise endeavour at best. To try to reduce the compatibility problem, two surveys were used and the average number of informally volunteered hours was taken; that said, these two source had estimates that were 25% different, making the accuracy of measurement seem somewhat suspect. The final issue relates to how the definition of a health volunteer matches up with the definition of a health employee. This important issue is discussed in detail later.

**Volunteering**

The first issue that needs to be addressed is what exactly is meant by voluntary labour. Volunteer work is essentially any work that is undertaken without receipt of payment.

There are two distinct classes of volunteers examined in this paper. Formal volunteers are those individuals who donate their time through formally recognized organizations, such as the United Way or the local hospital. Informal volunteers are people who provide assistance on their own in the community, without going through an organization. An example of an informal volunteer is someone who helps to prepare a meal for their elderly neighbour or coaches a children's sports team. Typically, researchers have focused on formal volunteers, often due to the fact that the data are better; however, this paper will examine both areas.

One further division of volunteering is used here. In order to focus on health, volunteering is divided into health-related and non-health-related activities. In the NSGVP both formal and informal volunteering are grouped based on the activity. A health volunteer will be defined as anyone who volunteered through a health organization.[2] This definition likely excludes many individuals who perform health services through other types of organizations, such as social service organizations, but is the best possible definition to isolate health volunteers from others. Informal health volunteers are a far harder group to classify, but are defined as those individuals who provided support for the sick or elderly on their own,[3] not through an organization. The definition of a health volunteer could include many other activities, such as help with housework or household maintenance, which often need to be done for those in poor health. It is often an inability to perform these tasks that leads an individual to need more formal home care or forces entry into a nursing home. The narrow definitions of health volunteers are selected for a number of reasons. First of all, if any distinction is to be made when comparing health volunteers to others, it is important to isolate health volunteers; if the definition of a health volunteer is too broad, this will be impossible. Secondly, with even these narrow definitions, volunteering represents a huge share of total care provision. In an area that has not been extensively studied it is better to focus study on the group that we are sure should be included, leaving further complications for the future. These narrow definitions provide a lower bound for the estimates of the total amount of volunteering and allow the clearest dividing line between health and non-health volunteers; their use allows us to focus more on the results of the analysis rather than on arguments over what does and does not constitute health volunteering. While this discussion would be very valuable, this paper is not the place for it.

**Literature Review**

It is not surprising that far less has been written about the supply of volunteer labour than about their paid counterparts; however, there has been some examination of the issue. Menchik and Weisbrod (1987) introduced a labour supply model for the voluntary sector and performed some simple empirical examination. In their model, two motivations for volunteering were identified: consumption and investment. The consumption motive

[2] The other formal categories are: cultural, educational, social science, environmental, housing, law/advocacy/political, philanthropic, international, religious, association/union, other.

[3] The other informal categories are: aid with housework, aid with household maintenance, shopping or driving to appointments, visiting the elderly, unpaid babysitting, writing letters or solving problems, unpaid teaching or coaching, business operation, other.

argues that the donation of volunteer time is a normal utility-bearing good; that is, individuals derive value from the act of volunteering. This value could come from other people's happiness entering their utility function, personal satisfaction as a result of volunteering, or a better reputation with other members of the community. The key point is that this is personal utility that is generated by the act of volunteering. The second motive, investment, relates to the expected future financial gains from participation in the paid labour force that could result from volunteering. These gains could be generated through the accumulation of human capital, which makes the individual a more productive worker, the making of valuable contacts that can aid the individual in the future, or the signalling value of volunteer work on a resume that helps an individual find employment. Generally, the literature since 1987 has focused on these two motives when examining an individual's choice of whether or not to volunteer. However, a 1997 study by Freeman introduced another interesting possibility. Volunteering might be a "conscience good" that individuals would rather not perform but feel compelled to do when asked; the social pressure with being personally asked to volunteer makes the individual feel morally obligated to help. Another possibility is that the individual has a latent demand for the good produced through volunteering and being asked brings this demand forward. Basically, this is an information or a search cost argument, which maintains that individuals may want to volunteer but the cost involved in finding out about an opportunity, usually time and effort, is too high. Being personally asked eliminates these costs and thus makes an individual more likely to volunteer. These ideas come out of his empirical work, where he found that the key determinant of the choice to volunteer is whether a person was personally asked to volunteer in the previous year. It is impossible to determine which of these two explanations applies.

The vast majority of other work on the voluntary sector has focused on the estimation of the determinants of the decision to volunteer and the choice of hours volunteered. Typically, a probit or logit estimation procedure is employed for the choice to volunteer and a tobit procedure used for the hours volunteered. One paper, Devlin (2000), employed a Heckman two-step procedure, like the one that is used here, but it focused on the decision to volunteer as the first stage and the individual's wage in paid employment in the second stage, to examine the impact of volunteering on wage outcomes. In this paper the second stage deals with the hours volunteered instead of the wage. One thing that virtually every study has in common is a focus on formal volunteering, volunteering through recognized organizations. Informal volunteering, helping out on one's own, has never been studied in great detail. One reason for this lack of study is the generally poor quality of data on the subject. Another possibility is that formal volunteering has only recently come to be studied in any detail so it is natural for informal volunteering to lag behind. Details of the findings of previous empirical work are discussed later where the independent variables in the regressions are examined.

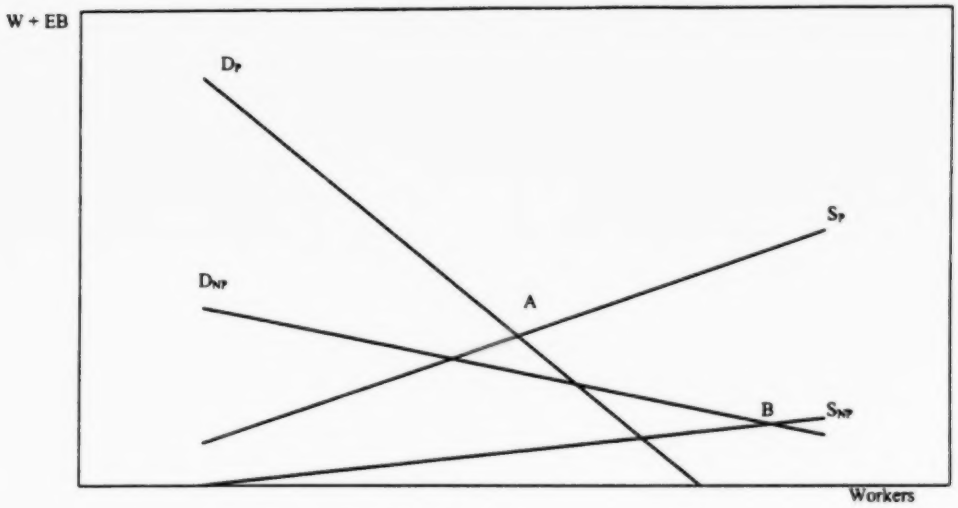
Despite the general lack of study in the area of volunteering, there has been work done in a number of countries. Countries with economic studies in the area include Canada, the United States, New Zealand, and the Netherlands.[4] In particular, study in Canada has intensified following recent surveys focusing on the voluntary sector.[5]

## The Voluntary Health Sector

The explanation of why people work is pretty straightforward—they are paid to. Why exactly people volunteer is far less certain, but a theory of consumption and investment motives is outlined above. The theory of volunteering can actually be thought of as an extension of the idea of compensating wage differentials discussed in the paid labour literature.[6] One reason certain occupations pay less than others is that the job characteristics are different and preferable in the lower paying job; the difference in the wage is just compensating for these differences in job characteristics. The motives outlined by Menchik and Weisbrod are identifying positive characteristics about the volunteering experience that make up the compensating differential that allows a zero wage to be paid.

The graph below depicts a situation where there are two labour inputs into the health sector, professional (P) and non-professional workers (NP); this would correspond to high and low skilled labour in general labour theory. Each of the two groups earns a combination of a wage (W) and external non-wage benefits (EB), the motivations described above. One note is that the external benefits would certainly be different for paid and unpaid employees since the motives for volunteering described above receive more value when the individual is not paid. For example, a volunteer would receive a more positive gain to their reputation than a paid person performing the same task. There are also two demand curves, one for each of the two worker types since they are not perfect substitutes. Because there is the possibility of substitution between the two groups their curves are linked; that is, any shift in a curve for one group will impact on the curves for the other group. One example would be a reduction in the supply of professional employees causing an increase in the demand for non-professional workers.

[4] This is by no means a comprehensive list, merely the studies I uncovered in the writing of this paper.
[5] 1987 Volunteer Activity Survey, 1997 NSGVP, 2000 NSGVP.
[6] First identified by Adam Smith in *Wealth of Nations* (1776), Chapter 10, page 100.




Point A would represent the equilibrium in the professional, paid market and point B would represent the equilibrium in the non-professional market. Note that if the demand for non-professional individuals were to sufficiently rise, or the supply to sufficiently fall, it is possible that individuals who are currently volunteers could theoretically earn a positive 'cash' payment on top of the external non-monetary benefits, whether in the form of actual money or something such as a tax credit. This is possibly the future that we might be facing in Canada, though this is purely speculation and a thorough examination is beyond the scope of this paper.

The above graph also shows the value of voluntary activity both to society and to the volunteers themselves. The area under the demand curve for non-professional staff is the value of the service to society since it represents the value society would pay, in wages and external benefits, to have the non-professional service. The fraction of this service that is provided by volunteers would represent the value of the voluntary activity. The fraction of the area under the supply curve due to volunteering represents the value to the volunteer since it represents the value they receive from the provision of the voluntary service. Empirically these values are far more difficult to measure, but they are conceptually identifiable.

**The Paid Health Sector**

When considering the role of volunteers in the provision of health, it is important to look at paid health workers as a reference group. There are two principal ways of defining employment in the health sector. 'Workers in health occupations' is often used to define a health employee; these are the nurses, doctors, and other professionals trained in the provision of health services. While this is a good measure of those who directly provide health services it omits a large part of the sector, the support staff who allow these professionals to perform their jobs. The other definition of the health sector is people who work in the health industry. The difference between the definitions is that the

industry definition includes both those people we typically see as health workers, such as nurses and doctors, as well as anyone who supports them. For example, when looking at a hospital the occupational definition of health workers would count doctors, nurses, technicians, and assistants who provide hands-on care; the industry definition would include all of the above plus the janitors, the accountants who work to manage the hospital's finances, and so on.[7] It seems that the industry definition is a better fit for overall comparison with the voluntary sector because volunteers are likely to be involved in far more than the actual provision of services and are actually more likely to be filling these support type positions. Of course, many informal volunteers will be providing hands-on care, but the full range of services provided by volunteers is better captured by the industry definition.

In the industry definition seven distinct groups of employees are identified.[8] Because the exact nature of the volunteer work is unknown from the data set, the best group for comparison is likely just the collection of all people working in the health industry; however, a couple of the subgroups could provide special interest. Formal health volunteers are those active in hospitals or nursing and residential homes, causing these groups to provide special interest. Informal health volunteers perform tasks that, if formally provided, would most resemble the home care or nursing and residential care categories. The table below[9] shows the division of the 1.7 billion health hours among the 7 groups as well as the average wage associated with each group.

| Group | Annual Hours | Hourly Wage |
|---|---|---|
| Total health industries | 1.7 billion | $18.87 |
| Drug manufacturing | 51 million | $29.18 |
| Physicians' offices | 148 million | $13.63 |
| Dentists and other practitioners | 200 million | $16.38 |
| Other ambulatory health | 106 million | $20.40 |
| Home care | 29 million | $14.31 |
| Hospitals | 762 million | $21.28 |
| Nursing and residential care | 407 million | $14.69 |

From the above chart it is apparent that the major employer of health personnel is hospitals, which account for approximately 45% of health employees. The other major areas for the paid health sector are nursing and residential care, and the offices of health professionals. One area where surprisingly few health professionals work is in home care, which accounts for less than 2% of the people working in the health industry. Home care is also the area where one would expect the most volunteering, particularly of the informal kind. This seems to paint a picture where volunteer labour is acting as a substitute for paid labour, by picking up the slack in an area where there are very few

[7] Doctors paid on a fee-for-service basis are omitted from both definitions since the Labour Force Survey only has data for wage earners.

[8] Drug manufacturing, Physicians, Dentists and other practitioners, Other ambulatory health care, Home care, Hospitals, and Nursing and residential care.

[9] Data is from LFS 1997.

paid health workers. It is impossible to determine if this informally volunteered labour is really filling in a gap left by a lack of paid workers or whether it is really just a complement to the professional home care that would exist regardless of the level of paid employees in the area. One would expect that a little of both is happening with informal volunteers performing tasks that complement home care workers when they are available, and serving as substitutes where there is a lack of paid help.

How does the amount of time volunteered compare to the amount of paid work in the sector? Estimates place the amount of formally volunteered hours in the health sector at 93 million and informally volunteered hours in health at 2 to 2.6 billion hours.[10] This implies that of the 4.1 billion hours[11] of health work done in Canada in 1997, 59% was provided by health volunteers.

**Valuing Volunteer Time**

Valuing time in the paid labour force is relatively simple; health employees worked 1.7 billion hours at an average wage of $18.87, leading to a total value of paid health labour of slightly over $32 billion. This calculation is far more difficult for voluntary labour because no wage is paid. There are two primary methods that could be used to estimate a wage rate for this unpaid source of labour.

***Value to Volunteer***

From the point of view of the volunteer, the value of the volunteer service must be worth enough to convince them to donate their time. Therefore, the value of the volunteer service can be valued at the opportunity cost of that time. Theoretically, individuals choose their amount of labour force participation so that at the margin the value of leisure time is the same as the value of time spent in the labour force, which carries with it a value of the wage rate the individual could earn. Therefore, one possible way to value volunteer time is to value it at the wage rate the individual could earn in the labour force.

While this method is well grounded in economic theory, there are many issues that need to be addressed. First of all, how does one value the time of someone who is not in the labour force, and hence who has no wage rate? This issue has been explored in the labour economics literature and the procedure that is typically used is that a regression is run on wage as a function of a variety of independent variables. These estimates can then be used to impute what the expected wages of those people who are not in the labour force would be if they were to work. The technical issue dealt with,[12] there are still many theoretical issues with this approach to volunteer time. Volunteering is not like paid work and hence valuing it as if it were presents many problems. Volunteering often involves a far less structured work environment[13] in a field that the volunteer is particularly interested in; to value this at the same rate as paid work would be ignoring

[10] Formal hours come from the 1997 NSGVP informal hours come from GSS98/Census96.
[11] 1.7 billion paid hours + 2.4 billion volunteer hours.
[12] There are still difficulties performing this task with the NSGVP, since the number of hours worked is not available, making the determination of an hourly wage rate impossible.
[13] Campbell 1993.

the differing job characteristics of paid and unpaid work. There are also the many external benefits of volunteering that accrue to the volunteer. First, there is presumably a certain level of personal satisfaction that is derived from the act of volunteering, as well as the value of the approval of other members of the community. Second, in line with the investment motive of volunteering, an individual who volunteers gains both experience and contacts that can improve earning potential in the future.[14] If one wants to accurately estimate the value of performing a voluntary service to the volunteer, one would have to net out those benefits that accrue to the individual. As a result, the external value of volunteering to the volunteer would likely be significantly less than the wage the individual could have earned if they were to work for pay instead of volunteering. A decent rough estimate of the wage of a given volunteer would be the average wage earned in the economy, and this would be particularly applicable when looking at an average wage for volunteers in general.

***Value to Organization/Society***

The appropriate value measure of volunteering for a specific organization, or for society as a whole, is the cost of replacing the volunteer with a paid worker. Again, theoretically this is sound but difficult to measure in practice. First of all, we do not know the exact nature of the volunteer's activities, so it is impossible to directly link them to paid alternatives. This is not an insurmountable problem since a rough estimate of their activities is possible. As discussed above, volunteer work is not the same as paid work. It is reasonable to assume that if the level of familiarity and relaxed atmosphere that is necessary to attract volunteers were implemented in a workplace, a lower wage would be demanded. Also, due to the nature of volunteering, people often have less developed specialized skills than a paid counterpart would causing less output to be generated for a given labour input. Despite all of these issues it is possible to estimate an upper bound for the value of the volunteer activity as the wage that is earned by paid employees in the sector. A lower bound might be the minimum wage, which is the lowest possible wage the organization could pay an individual to replace the work done by a volunteer. However, this is assuming that all workers are equally productive. It is possible that the industry could replace the output of one hour's worth of voluntary effort with less than one hour's worth of paid effort, even at the minimum wage, depending on the relative productivities of the volunteer and the paid worker. Since we do not even have a good idea of what volunteers do, the idea of measuring their productivity is not currently feasible; it is merely introduced to state that the minimum wage might not be a lower bound. In the health sector, a variety of possible wages exist such as the average wage paid to workers in the health industry, the wage paid to workers in an industry segment that most closely resembles the work done by volunteers such as home care, or the wage earned by workers in the health occupation that most closely resembles the work done by volunteers, likely assisting occupations in support of health services.[15]

[14] Day and Devlin 1996, Devlin 2000.

[15] The seven LFS occupation classifications in health are physicians, dental health occupations, other diagnosing and technical professionals, other professionals, nursing, technical occupations, and assisting occupations in support of health services.

| Method | Wage Rate per hour | Volunteering Value[16] |
|---|---|---|
| Minimum Wage | $6.48 | $15.6 billion |
| Assisting Occupations | $12.70 | $30.5 billion |
| Home Care | $14.31 | $34.3 billion |
| Economy-Wide Average | $15.56 | $37.3 billion |
| Health Industry | $18.87 | $45.3 billion |

Given the lack of certainty as to an optimal approach to valuing volunteer time, the chart above contains a variety of possible estimates for the year 1997. It should be remembered that the narrowest possible definition of a health volunteer was employed for both formal and informal volunteers. Thus, each value above represents a lower bound for health volunteering at each wage level. Given the discussion above, the best estimate of the value of volunteering in 1997 is likely somewhere in the $20-30 billion range. Paid labour in the health sector earned approximately $32 billion in 1997.

## Regression Results in Volunteering Decisions

Now that volunteering has been placed into the context of the paid health sector, and established as a major provider of health service, we turn to the examination of the personal characteristics that influence an individual's decision to volunteer and their choice of volunteer hours.

### Classification of Variables

Before moving on to describe the individual variable details, it is worth taking the time to provide a structure into which they can be placed. To address this issue two questions need to be answered. First, what are the broad factors that determine an individual's propensity to volunteer and the amount of time volunteered? Second, how do individual variables fit into these broad categories? A description of the various categories can be found below, followed by a description of the individual variables that fall into these categories. It should be noted that individual variables will typically impact more than one broad category, often in contradictory ways. Variables will only be included in the area they best match but their impact on other categories will be included in their description.

#### *Time*

The first broad factor that influences an individual's volunteering decisions is how much time the individual has available. Volunteering takes time, of which each person has a limited supply; in fact, the price of volunteering to an individual is the opportunity cost of the time used. General labour supply work focuses on the distinction between labour, defined as work for pay, and leisure, which encompasses everything else including recreation, household chores, and even sleeping. This model can be easily extended to include volunteering as another competing possible use of time. Given the limited supply

[16] Using 2.4 billion hours.

of time available to an individual, any time used in non-volunteering activities would be expected to take away from the time spent in the voluntary sector.

***Knowledge and Ability***

A prerequisite for any decision is the knowledge of the options available and the ability to perform the service. An individual's knowledge of what volunteering opportunities exist is essential in determining their time allocation. The more potential voluntary activities that a person is aware of, the more likely that individual is to find one that appeals to him or her. Unfortunately, we have no way to measure a person's knowledge of the options available; however, one would imagine that there are factors we can measure that would be correlated with this knowledge. For example, the longer an individual resides in a community and the more people that an individual meets, the more likely this person is to acquire knowledge of the voluntary possibilities to choose from. Likewise, the more able a person is, either physically or mentally, the more options that individual has to choose from and the more likely this individual will volunteer.

Knowledge of opportunity is actually another way of interpreting Freeman's result that being asked is the key determinant of volunteering. The more people in the voluntary sector individuals know, the more likely they will be asked to volunteer. Being asked to volunteer is really just one way that a person can realize an opportunity to volunteer exists.

***Social Attitudes and Individual Preferences***

The way that society, or a unique culture within society, views the role of an individual as a volunteer makes up a key input into the decision process of an individual. These societal factors are components of an individual's preferences, since one's attitudes are at least partially shaped by society, and one's behavioural choices take society's reactions into account. As a result, environmental factors that surround an individual will have an important impact on the choices that are made.

| **Time** | **Knowledge & Ability** | **Attitudes & Preferences** |
|---|---|---|
| Marital Status | Age | Sex |
| Kids 0-5 | Kids 6-18 | City Size |
| Employment | Education | Religious Devotion |
| | Health | Religion |
| | Duration | Province |
| | Birth Country | Youth Experience |
| | | Income |
| | | Year |

## The Model and Methodology

Before discussing the specifics of individual variables, it is important to establish the model that is estimated and the procedures that are used. We are essentially concerned with answering two questions for a variety of different groupings of volunteers. First, what are the key determinants that weigh in an individual's decision to volunteer? Secondly, what are the key factors that determine the number of hours volunteered by an individual? These two questions will be asked with six different classes of volunteers; namely, formal volunteers, formal health volunteers, other formal volunteers, informal volunteers, informal health volunteers, and other informal volunteers. For each group two equations need to be estimated:

Participation = f (time, knowledge and ability, social attitudes and preferences)
Hours = f (time, knowledge and ability, social attitudes and preferences)

Each of these two equations poses econometric problems, and their combination even more so. The choice to volunteer is a yes or no decision, implying that a limited dependent variable model will be required. Fortunately many models, such as a probit or logit, have been developed and used to study volunteer activity. Hours volunteered also presents a problem since observation of hours is censored in that they cannot be below zero even if this is the value that would be preferred by the individual. This problem has been dealt with in the literature with the use of a tobit model which corrects for the bias of censored data. However, one further problem exists in that not only is the hours data censored, it is also subject to selection bias in that we only observe the hours for people who make the choice to volunteer. While a tobit model allows us to estimate the contribution of various independent variables to the hours decision, it restricts the coefficients on these variables to be the same regardless of whether or not an individual volunteered. There is an alternative technique that deals with the issues surrounding both the decision to volunteer and the choice of hours in a more appealing manner because it deals with the selection issues and allows the coefficients in the hours equation to vary depending on whether or not the individual is a volunteer.

The Heckman selection model, or Heckman two-step estimator, was developed in by James Heckman in 1979[17] to deal specifically with the problems encountered here, though it has usually been applied in the paid labour supply literature. Generally any estimate of an hours regression that does not factor in selection bias due to the fact that hours are observed only if an individual chooses to participate suffers from an omitted variable, namely the impact of selection on hours. The Heckman procedure seeks to remedy this bias by estimating the hazard rate, basically a measure of the odds of selection in a first step and then including this estimate in the hours regression; this estimate of the omitted variable is usually called the inverse Mill's ratio. The Heckman procedure is made up of two stages. In the first stage, a probit model is estimated on the decision to volunteer with data from all volunteers and non-volunteers, and the inverse Mill's ratio is calculated. A second stage is then undertaken with the estimation of an

[17] Heckman (1979).

OLS model on hours using data from those individuals who volunteered while including the inverse Mill's ratio to account for selection bias.

More formally,

selection equation: decision to volunteer (probit)

$$V_i = X_i\beta + e_{1i} \quad (1)$$

regression equation: choice of hours (ols)

$$H_i = Z_i\gamma + e_{2i} \quad (2)$$

Where $e_1 \sim N(0,1)$

$e_2 \sim N(0, \sigma)$

$corr\ (e_1,e_2) = \rho$

Where V is a 1-0 variable measuring if an individual volunteers, H is the number of hours volunteered, and X and Z are vectors of independent variables. It is the correlation between the error terms that generates the bias that the Heckman procedure seeks to avoid. If $\rho = 0$ then the Heckman procedure would add no more information than simply running the two regressions separately. If $\rho = 1$ then the tobit model emerges. If $0<\rho<1$ then some selection process is taking place and the Heckman model provides insight into that process.

One final note concerns the particular data set employed here, the National Survey of Giving, Volunteering, and Participating. Because the survey data requires the use of weights due to the sampling procedures, it is necessary to use weighted regression techniques. Fortunately, sample weights are available for each individual in the sample, allowing us to adjust for the relative importance of each observation.[18]

***Sex and Time***

By employing a dummy variable to capture the difference between males and females and between 1997 and 2000, it is being assumed that there is only a fixed difference between them and that all the coefficients on the other variables are the same. This simply might not be the case.

It is possible to test if the coefficients are the same across sexes or time periods. An unrestricted regression is run where the coefficient on each independent variable is allowed to vary by group (male versus female, 1997 versus 2000). A Wald test on whether the coefficients on each variable are identical is then run, with the resulting statistic conforming to a Chi-squared distribution.

$$V_i = \beta_m X_{mi} + \beta_f X_{fi} + e_i$$

Test ho: $\beta_m = \beta_f$, for all $\beta$

[18] For a more detailed discussion on the use of weights in regression analysis see Deaton (1997).

The results of the Wald test indicate that for formal volunteering we can reject the equality hypothesis at the 1% significance level; this implies separate regressions should be run by sex. For informal volunteering, it is possible to reject at a 2% significance level. In the interest of space, the regressions by sex, and Wald statistics, are included in an appendix to this paper.

The same Wald test described above was performed with respect to the time of the survey, 1997 versus 2000. The results of the Wald test indicate that for formal volunteering we can reject the equality hypothesis at the 1% significance level. For informal volunteering it is also possible to reject at the 1% significance level.

The regressions by sex and by time period, along with their respective Wald statistics are also included in an appendix to this paper. Any insights from these other more stratified regressions will be discussed with the results from the regressions where sex and time are dummies, but a detailed discussion of the actual results is omitted.

**Regression Results**

The following section describes the independent variables, the expected results based on theory and literature, and the actual results from the regressions. The actual regressions are included in an appendix, along with a list of all the independent variables. In general the results for formal health volunteering are similar to those for other forms of formal volunteering, other than the fact that the estimates tend to be smaller. This discrepancy is likely due to the limited variation caused by the much smaller sample of formal health volunteers; however, it is also possible there is a real difference underlying why health volunteering is less responsive to the independent variables examined. It is possible that there is a key characteristic we are not observing here.

**Time Variables**

***Marital Status***

The interaction of marital status and volunteering is complex since it likely fits into all three dimensions. The primary impact on time is that married individuals often have more time available to them because household chores are shared between the two individuals freeing up some time for other activities. This is not entirely clear because it is possible that marriage causes there to be more household activities that need to be performed or less time to devote to individual pursuits outside the home because more time is spent on activities with one's spouse. The impact on the knowledge of voluntary opportunities is less uncertain. By being married, an individual is more likely to have knowledge of volunteering opportunities directly through his or her spouse, or indirectly through contacts the spouse may have. As for preferences, it is also likely that if one member of a couple volunteers, the other will follow suit. The literature to date has found that being married has a positive impact on the choice to volunteer but no significant impact on the number of hours volunteered.

The regressions undertaken in this paper seem to generally agree with what has been found before. Being married increases the chance of volunteering, both formally and informally, by 4-5%. There is also no significant impact on the number of hours volunteered informally; however, marriage reduces the number of hours volunteered formally by approximately 14 hours per year, 27 hours per year for health volunteers. These results seem to confirm the knowledge and preference impacts of marriage on an individual described above, but seem to indicate that marriage actually leaves an individual with less time to volunteer. Marriage seems to have a much larger impact on inducing males to formally volunteer than females. Why this exists is uncertain but it is likely related to preferences.

***Children Aged 0-5***

The presence of young children in the household is likely to significantly reduce the likelihood of volunteering and the hours volunteered, and this is supported by the literature. Young children demand a great deal of care and reduce the flexibility of parents concerning when and where they volunteer, since often the parent must bring along the child. This might not be as large a factor for informal volunteers since the activity is often performed in the home of a friend or family member, a much more suitable environment for young children.

The presence of young children is found to significantly reduce the probability of volunteering formally, by about 7%, without having a significant impact on the number of hours. This implies that children act as a barrier to entry, but do not alter behaviour once entry occurs. Strangely, the opposite is found for informal volunteering with no impact of young children on the decision to volunteer but a significant impact, 1.5 hours less volunteered per week, on the amount of time volunteered.

***Labour Force Status***

The labour force status of an individual is likely to have two strong opposing effects on volunteering. First of all, time spent in the labour force directly translates into less time for both leisure and volunteering. In contrast, individuals who work are likely to have a wider group of contacts that will increase their knowledge of the voluntary sector and their chance of being asked to participate. How do these two opposing forces net out? The literature supports the intuitively appealing finding that for full-time employees, the time effect dominates, while for part-time workers the knowledge effect holds more sway. Thus, full-time employees volunteer less often, and part-time employees more often, than those outside the labour force. Surprisingly, employment status has not been found to have a significant effect on the hours volunteered.

This study confirms earlier findings about formal volunteering, specifically that full-time employment decreases the likelihood of participation by about 7%, while part-time work increases the odds by about 3%. Unemployed people are found to be no different from those outside the workforce. In terms of hours, a significant negative effect, 24 hours per year, is found for full-time workers, with part-time work having no impact on hours. This fits very nicely with the theory that full-time workers would be time-constrained and substitute between work and volunteering. Since part-time employees are not likely to be

as time constrained, no substitution is taking place. Informal volunteering has a very large negative impact of employment, 2.5 hours per week for both full and part-time workers, though no impact on the participation decision is found.

**Knowledge and Ability Variables**

***Age***

The stage of life of an individual is likely to have a large impact on volunteering activity; in fact one expects it to follow a pattern based on an individual's life cycle. Young people tend to be physically healthier but have less developed skills as well as less understanding of volunteering possibilities, not to mention the different preferences of younger and older individuals. As people age, they are expected to volunteer with greater frequency as their skills and knowledge develop to allow a wide range of volunteering possibilities. Finally, after a certain point physical health diminishes, making volunteering a more difficult proposition. Thus, as has been found in the literature, we expect both likelihood and hours to rise as an individual ages before falling in later life. This is captured by the inclusion of both an age and age2 term in the regression.

Age was found to have no impact on either the decision to volunteer or on the number of hours volunteered other than for health volunteers whose participation decision followed the life cycle pattern described above. This would support the argument that age is not an important determinant of volunteering activity, though a real effect might have been found if more data was available. Also, here we have controlled for health and education, two effects that would be picked up by age when they are not controlled for.

***Children Aged 6-18***

While children aged 0-5 are predicted to reduce the amount of voluntary activity, children aged 6-18 are likely to significantly increase it. Older children need far less intensive care than younger children, freeing up a great deal of time. Children are also often involved in activities, such as sports teams or school clubs, which often require a significant contribution of volunteer time. These activities increase a parent's knowledge of where he or she could contribute and the personal value of the volunteer experience when the activity involves a parent's child.

The presence of older children is found to have the predicted impact of increasing participation in formal volunteering, by approximately a 7% chance. Not surprisingly, this impact is not found for health volunteers since parents with school-aged children are more likely to volunteer in other activities. No impact on informal volunteering is found, again not surprising since many voluntary activities with school-aged children are formal in nature.

***Education***

Education has long been found to be a major determinant of civic participation in general with volunteering being a specific instance. In fact, education has been found to be a key determinant of both the decision to volunteer and the choice of hours volunteered. This is not a surprise since it should increase both the number of contacts as well as the number

of possible voluntary activities. One should be very careful when interpreting this variable. In a twins study conducted in New Zealand,[19] Gibson finds that education actually reduces the amount of time volunteered. He argues that education is determined by many of the same unobserved family factors that affect the decision to volunteer, such as work ethic. Since we do not control for these unobserved family factors in this study, we expect to find that more educated individuals will volunteer both more often and more hours, but when interpreting the variable one needs to take Gibson's work into account.

Education has an enormous impact on both the decision to volunteer and the number of hours volunteered. Those individuals with no high school education are 8% less likely to participate in formal volunteering than those with at least some high school education, while those with a university education are 18% more likely (these numbers are 4% less likely and 4% more likely for informal volunteering). In terms of hours, university education adds 24 hours per year to formal volunteering with no significant impact on informally volunteered hours. These results are understandable when one considers that formal volunteering would likely demand more refined skills and be more reliant on contacts and requests to generate volunteers; all of these factors are correlated with education. Some anomalies without intuitive sense are that the impact of education is far larger in the 1997 data compared to the 2000 data, and that the impact on informal volunteering appears to be significantly larger for males.

***Health***

The health of the individual has rarely been considered as a determining factor for volunteering; only Day and Devlin (1996) include it. However, it does have a strong intuitive argument for inclusion, namely that people who are unhealthy are not likely to be able to help others and are more likely in need of help themselves. Day and Devlin found that an individual's good health had a positive effect on both the probability of volunteering and on the number of hours volunteered.

This study confirms that an individual's health is an important determinant of the likelihood of this individual volunteering, though it is poor health that has the largest impact. Being in excellent or very good health increases the probability of volunteering formally by 5-6% with no significant impact on the likelihood of informal volunteering. Poor health reduces the chance of formal volunteering by 8% and that of informal volunteering by 23%.

***Duration in Community***

This is another factor that has been rarely studied, and is only found in a 2000 study by Devlin. One would expect that the longer an individual lives in a community the wider his or her net of contacts and the more likely he or she will be involved in a voluntary activity. Devlin only looked at duration in the context of likelihood of volunteering and found that the longer individuals have been residents of a community the more likely they are to volunteer. While hours were not studied, one would not expect duration to have a significant effect since it would play a far greater role in increasing knowledge of

[19] Gibson (1999).

volunteering possibilities in the community with little impact on the amount of time spent in volunteering activities.

The results regarding duration in this study are perplexing. Compared to living in a community for between two and six years, those who have lived in the community for less than two years, and those who have lived in the community for more than six years are both more likely to formally volunteer; there is no impact on informal volunteering or formally volunteered hours. Why this pattern exists is a mystery, though the effects are quite large, with those whose residence has been less than two years 5% more likely to volunteer and those whose residence has been more than six years 9% more likely.

***Birth Country***

This variable distinguishes between those born in Canada and those born outside of Canada. One would expect there to be a lot of knowledge of the role of the voluntary sector and the possible opportunities for volunteering to be acquired while growing up. Individuals born outside of Canada are far less likely to know of the various volunteering options available. Also, it is likely new Canadians will have fewer community contacts, which are often the catalyst for volunteering, either because a contact requires assistance or personally asks an individual to volunteer. While one would expect foreign-born individuals to volunteer less often, once they are volunteers there is no reason to suspect they would contribute a different quantity of hours than native-born Canadians.

As expected, being born outside of Canada reduces the probability of volunteering by 7%, both formally and informally.

**Attitudes and Preferences**

*Sex*

For good or ill, there is a perception of the differing roles of men and women in society, and this can affect the decision to volunteer and the number of hours volunteered. While not universal, women tend to spend more time with the children and in the community; as a result, one might expect them to have a greater knowledge of, and more opportunity to perform, voluntary activities. Conversely, the burden of household work falls most heavily on their shoulders. All other things being equal, this causes women to have less leisure time available to devote to volunteer work. This explanation is supported by previous studies, which have found that while women volunteer more often, on average they tend to volunteer fewer hours than their male volunteer counterparts.

The expected finding of males volunteering less, 2-3% less likely, is found here; however, this finding is totally driven by volunteering in health. The impact of being male reduces the chance of formal health volunteering by 3% and informal health volunteering by 8%; in contrast, being male has no impact on the probability of volunteering formally in other areas and it increases the chance of informal volunteering in areas outside of health by 6%. These findings are quite sensible since the paid workforce in health is predominantly female and it is women who generally take on caregiving roles in daily life. In terms of hours, males volunteer far more hours formally,

37 per year, and far fewer hours informally, 1.5 hours less per week. This could simply be a preference of males for more formal forms of volunteering with total hours volunteered being the same between the sexes. More detail on the differences by gender can be found by examining the regressions by sex in the appendix to this paper.

*City Size*

Small towns have often been pictured as close-knit groups interacting with friends more often and in closer ways than people in large cities. While this is certainly a stereotype, it is likely that people in smaller towns have a greater sense of belonging to a community and a greater knowledge of what goes on in that community. One would imagine that an increased feeling of community would lead to an increased chance of voluntary activity being performed, not to mention the fact that with closer relations there is likely to be more social pressure to participate in the community. Studies have found that people in larger cities volunteer less often but that city size has no significant impact on the number of hours volunteered.

City size is found to have no impact on informal volunteering or formally volunteered hours. The sole impact is that larger cities tend to decrease the chance of formal volunteering, by about 2%, and small towns increase the likelihood by approximately 5%. Formal health volunteering seems to follow the opposite pattern, with small towns slightly decreasing the likelihood. This anomaly is likely caused by the fact that formal health volunteering is defined as taking place in hospitals and nursing homes, few of which exist in areas of low population.

***Religion and Religious Devotion***

Religion and the intensity of religious belief are both likely to significantly impact decisions around volunteering. Religion makes up a large part of an individual's culture and the expectations placed on that person. Many religions advocate that their members perform voluntary service in the community and a large amount of social pressure to volunteer may result. Couple this with increased community contact through religious organizations, many of which are active in the provision of volunteer work, and the odds of volunteering invariably increase. Because many volunteer organizations are religious in nature it is possible that the religious association acts as a barrier for people not from the more common Christian religions in Canada. Thus one would expect that, in general, religious people would volunteer more often but individuals from less prevalent religions in Canada would volunteer less often than those from the more common religions. Literature on volunteering shows that religious people volunteer both more often and for more hours than their less religious counterparts. Very little has been found on how the denomination of the religious person affects volunteering decisions.

While the intensity of religious devotion seems to have no significant impact on informal volunteering, it does increase formal volunteering. Very religious people are 8% more likely to volunteer formally than those who are only somewhat religious, who are 4% more likely to volunteer than those who are not very religious. The intensity of devotion only seems to hold for those individuals who are at least a little religious, since those individuals who are not at all religious are only 4% less likely to volunteer than those

who are very religious. This makes sense since the level of devotion would correspond to the level of activity in the religious community, a community non-religious people are not a part of. The only impact on hours seems to be that if an individual is very religious he or she will volunteer an average of 32 more hours per year than an individual with any other level of devotion.

In terms of the denomination of religion, being a member of any denomination, when compared to being non-religious, increases the odds of informally volunteering, and any denomination but Catholic increases the odds of formal volunteering. Denomination has no impact on hours. It was somewhat surprising to discover that being a member of other, generally non-Christian denominations increases the probability of volunteering by more than being a member of the more traditional Christian religions. The expectation of denomination acting as a barrier to entry does not seem to be taking place.

***Province***

A very rough estimate of the social culture that an individual lives in is his or her province of residence. While by no means a perfect representation of the social attitudes an individual faces, an individual's province at least allows for some variation by region of Canada. Studies have generally found that persons residing in Quebec exhibit below average amounts of volunteering, and those residing in the Prairie provinces exhibit above average amounts. There is no real reason for a priori predictions on the impact of a given province on volunteering decisions beyond the fact that significant differences between the various regions likely exist.

The regression results do indicate that there are significant differences among the provinces of Canada. Canada can be roughly divided into three groups. Ontario, British Columbia, and the Atlantic provinces all exhibit very similar behaviour other than the fact that informal volunteering is slightly more likely in B.C. and slightly less likely in Newfoundland when compared to the rest of the group. Quebec shows a lower likelihood of formal volunteering, by about 4%, but this is contrasted with the fact that the hours volunteered are likely to be higher, by an average of 29 per year. Finally, the Prairie provinces show significantly more participation in formal volunteering, 6-10%, and informal volunteering, 1-7%; however, this is contrasted to the lower average number of hours volunteered formally, by about 20 hours per year. These patterns highlight an important result. As participation increases it seems the average number of hours falls. This will be discussed further in the next section of this paper.

One point of concern is that the results from the 1997 survey and 2000 survey are very different for informal volunteering in two provinces. A person from Quebec or Alberta, as compared to one from Ontario, was 5% less likely to volunteer in 1997 but 6% more likely to volunteer in 2000. There is no logical reason to explain this fundamental change, which makes one suspect the data quality of the informal volunteering.

***Income***

Income is actually a difficult variable to place within this framework. It is certainly correlated with the number of hours worked and thus has a time dimension. It also is

correlated with age, education, and other factors that determine the wage an individual is paid. On top of that, it has been argued that income is endogenous and itself dependent on the amount of volunteering that an individual performs. It is included in this section as a measure that directly enters an individual's optimization decision through that individual's budget constraint. If one considers volunteering to be a normal good, then the more income available to people the more volunteering they would be expected to do; they would 'purchase' more time to spend on volunteering by working less. Of course there is an opposite substitution effect in that the higher an individual's income the higher the opportunity cost of not working and the higher the price of spending time volunteering. When you also factor in that income is correlated with time at work, and the more time spent working the less time that is available for volunteering, the overall impact of income on volunteer activity is uncertain. The literature has shown that income is positively correlated with the likelihood of volunteering, with no consensus found for the relationship between income and the amount of hours volunteered, though studies lean towards it being negative. In terms of the endogeneity issue, while a long history of volunteering could impact labour income through a development of contacts and human capital, it is unlikely a joint decision that has any short-term effect. In fact, in a study performed by Day and Devlin (1996), they found that treating income as endogenous did very little to alter any of their results.

In this study, which agrees with the literature, income is found to be positively correlated with the likelihood of formal volunteering, and negatively correlated with the number of hours volunteered formally. No impact is found on informal volunteering.

***Youth Experience***

Youth experience is captured in three variables that attempt to measure how contact with voluntary activities while young affects an individual's adult behaviour. The three variables measure whether an individual saw a role model volunteer, a parent serve as a volunteer, or whether that individual was helped by a volunteer while young. While there is no literature available to help predict the impact of these variables, it makes intuitive sense that the more contact individuals had with the voluntary sector, particularly through people close to them, the more likely these individuals will be to participate later in life.

These three variables turn out to be key determinants of both formal and informal volunteering. Seeing a role model volunteer while young increased the likelihood of volunteering in adulthood by about 4%,[20] being helped by a volunteer while young increased the likelihood by 6-7%, and seeing a parent volunteer increased the likelihood by 8-10%. These results indicate that there is significant transfer of attitude towards volunteering from generation to generation, causing any shock, either positive or negative, to have long-term implications.

***Year***

Finally, there could be a shift in society's attitude towards volunteering from one year to the next. It is unknown what to expect from this variable since it is a measure in the shift from 1997 to 2000, the two survey dates. Early studies show that in Canada, the trend

[20] Actually reduces likelihood of informal volunteering by 1%.

has been toward less likelihood of volunteering but more hours for those who do volunteer.[21]

There has been a large change from 1997 to 2000, possibly indicating a fundamental change in how volunteering is performed in Canada. The probability of serving as a formal volunteer in 2000 is 11% lower than in 1997, and the average number of hours volunteered is on average 28 hours less, all other things being equal. This represents a dramatic decrease in the amount of voluntary effort in Canada. On the flip side, the probability of volunteering informally increased by 6%, though hours could not be tested due to the absence of informal hours data in the NSGVP surveys. Whether this represents a shift in preferences towards informal volunteering or whether informal volunteers pick up the slack when formal volunteers are unavailable is unclear, but this is an interesting question that could have important implications for how we deal with future changes in voluntary activity.

**Summary of Key Results and Policy Implications**

Given the lengthy list of variables in the previous section, let us step back and look at some of the most important results. Education is likely the single largest factor that determines whether or not an individual will volunteer; the key question to examine when looking at policy options is why education is so important to the decision to volunteer. One suggestion is that more educated people have access to a wider variety of volunteering opportunities, either through an increased range of abilities or an increased knowledge of the options available. One policy answer to this explanation is to educate people regarding volunteering opportunities. Another possible explanation is that more highly educated people have a wider group of contacts who might influence an individual to volunteer. This is possibly tied to the likelihood of being personally asked to volunteer, something we could not measure directly but that Freeman (1997) found to clearly be the dominant determinant of the decision to volunteer. If this is the case, the initiative would likely have to come from the individual charities to get their members to try to personally request aid from either their acquaintances or members of the public in general. The third possibility is that, as Gibson (1999) found, education does not increase participation in volunteering; in regressions it is merely picking up unobserved individual characteristics such as ability or family background. It is hard to imagine a policy proposal that would have a significant effect if this is the case. The key point is that with so many different possible explanations, implementing any policy before further study can identify what underlying factors are driving education is a risky proposition.

Something new in this study that has not been examined before is how important youth experiences are in contributing to adult volunteering behaviour. Being exposed to volunteering at an early age through the example of parents or role models, or being on the receiving end of voluntary behaviour greatly increases the chance of volunteering later in life. Some provinces in Canada have instituted policies that force young people to volunteer in order to complete secondary school, hoping that the youth experience will translate into adult volunteering. It is doubtful that the forced interaction with the

[21] Caring Canadians, Involved Canadians 2001

voluntary sector is likely to be as beneficial as seeing one's parents doing so from personal choice, but perhaps creating knowledge about the sector will increase the number of volunteers in the future. The other thing that the importance of youth experiences introduces is the potential, and danger, of cumulative causation. As more people volunteer, more youths will come into contact with the sector, and more will likely volunteer later in life, thus creating a virtuous circle. However, the opposite is also true in that if the number of volunteers falls this could lead to a downward spiral in the rate of volunteering over time. It is with this in mind that the data showing people 11% less likely to formally volunteer in 2000 than in 1997, all other things being equal, looks particularly ominous. Granted this is partially offset by increased informal volunteering, but whether informal volunteering leads to the same positive impact on adult behaviour is unknown.

Another variable that is not often studied, but that has an enormous impact on voluntary behaviour, is the health of an individual. It is intuitively simple to recognize that a person in poor health is far less likely to contribute time and effort to help others. The positive externality of a strong health system contributing to healthier workers and hence more output in the paid sector has often been discussed. The impact of health on the voluntary provision of time is likely far greater, since there is not the same pressure to show up as there would be in a place of employment. When looking at volunteering in health another potential issue of cumulative causation arises. A strong health system needs fewer volunteers, due to fewer people being ill, and has more available since they themselves are healthy. In contrast, if the health system weakens more people fall ill, causing more care to be required. This will create a higher demand for health volunteers, particularly since they likely serve as substitutes for paid health workers in at least some cases; however, the supply of health volunteers will shrink due to a lower level of health among volunteers which will put even more stress on the system. The obviously policy conclusion is to sufficiently invest in the health system to prevent this negative spiral from happening.

There is an important caveat to keep in mind when planning policy options. One should not expect that if one increases the number of people volunteering these new individuals will each provide the previous average number of hours. It is unreasonable to assume that people who are somehow enticed to volunteer will have the same characteristics of those who already volunteer, otherwise they would have been volunteering already. This fact can be seen in the provincial data where those provinces with higher levels of participation also tend to have lower average levels of hours volunteered. When the rate of volunteering is increased it is the person at the margin that is being added, not the highly committed volunteer you already have. A second factor is that the demand for volunteers is not infinite. There are a certain number of tasks to be done; thus, adding volunteers could cause some crowding out of the time already provided, lowering the average number of hours per individual.

Finally, what makes health volunteers different from other volunteers? The specific nature of the question creates problems due to the limited sample of health volunteers available for analysis. With more data available it is likely that other distinctive

characteristics would emerge, but even with the data that exists two key distinctions are visible. First of all, men are far less likely to volunteer in health; in fact, the general observation that men are less likely to volunteer is entirely driven by the health sector. This corresponds directly with the observation that the majority of employees in the paid health sector are also women. The second distinction is that while small towns increase volunteering in general they decrease formal volunteering in health. This is undoubtedly caused by the fact that the hospitals and nursing homes, where formal health volunteers participate, are not found in the same density in more rural areas. This raises the potential of an untapped pool of individuals in the smaller towns who would be willing to provide their time if a suitable institution were to be put in place.

## Conclusion

This paper has been an exploration of the voluntary sector in relation to health focusing on two questions. First, what is the contribution of volunteers to the Canadian health care system? Second, what are the key determinants of voluntary behaviour?

The contribution of volunteers to the health care system is huge. Formal volunteers, who have been the focus of most study, contribute approximately 93 million hours per year, a sizeable amount but not striking compared to the 1.7 billion paid hours in the sector. However, the 2.3 billion informally volunteered hours in health represent a resource that is even larger than the paid workforce. The valuation of this time is highly problematic depending on the methodology chosen. Estimates here range from $15 billion to $45 billion, though most likely the estimate should lie in the $20-$30 billion range; this implies that volunteers in health represent an extremely valuable resource that is never discussed when the purely monetary costs of the health system are examined. The exact value is not the important fact. The huge role volunteers play in the provision of health is.

The second question has a longer history of examination both within Canada and in other countries. This study benefits from four key features. The National Survey of Giving, Volunteering, and Participating is a rich new data set that allows many new issues to be examined. From this data set two new key determinants of voluntary behaviour, youth experience and health, have been identified; these, along with education, appear to be the dominant determinants of volunteering. The one glaring weakness with this data set is the lack of information on informally volunteered hours that limits a great deal of useful analysis that could be undertaken. The second unique feature is a focus on health volunteers. Unfortunately, due to a limited quantity of data, little concrete can be said other than it is a female driven volunteer force. It is actually solely this health component that has led researchers in the past to claim that females volunteer more often than males; other sectors see equal male and female volunteering. Third, and likely most importantly, informal volunteering was looked at. Due to data problems the analysis was somewhat limited but did confirm that informal volunteers behave similarly to formal volunteers in many ways. A key point arising from the analysis is the identification of just how large a

contribution informal volunteers make, particularly in health. Finally, the Heckman two-step estimation procedure is extended into the study of volunteering.

The only question that remains is where to go from here. The key result from this study is that informal volunteering is of huge importance in health. As a result, more detailed study of the sector is in need; particularly, better data on the hours volunteered informally needs to be collected. The activities performed and how these are integrated with the activities of paid workers is also an important area for further research; this applies to both formal and informal volunteers. Finally, how the sector itself is organized and how this has changed, or could be changed, is a possibly valuable avenue to pursue.

## Appendix I: Formal Volunteering

The table below shows the results from the Heckman 2-stage regression where the choice of whether or not to volunteer constituted the first stage, and the choice of hours the second stage. Variables significant at the 5% level are marked with an asterick (*). Variables not included in the regression are marked N/A.

| Category | Variable | All Participation (dF/dX) | Health Participation (dF/dX) | Non-Health Participation (dF/dX) | Annual All Hours | Annual Health Hours | Annual Non-Health Hours |
|---|---|---|---|---|---|---|---|
| **Time** | Married | .047456* | .006929* | .037385* | -14.4600* | -27.2373* | -15.8911* |
| | Kids05 | -.072895* | -.017150* | -.048300* | -5.4491 | -13.8655 | -9.3601 |
| | Full-time | -.070919* | -.013506* | -.051544* | -24.3348* | -27.6517* | -23.9719* |
| | Part-time | .030020* | .001187 | .025072 | -8.2418 | -14.5003 | -8.1137 |
| | Unemployed | -.000434 | -.001778 | .001075 | 1.1090 | 8.6616 | .4753 |
| | | | | | | | |
| **Knowledge & Ability** | Age | .000559 | .001140* | -.000894 | 1.0730 | .4631 | 1.7900* |
| | Age2 | -.000023 | -.000010* | -9.48e-06 | .0066 | .0129 | .0009 |
| | Kids618 | .077375* | -.001792 | .073128* | N/A | N/A | N/A |
| | No hs | -.084112* | -.019575* | -.064053* | .9560 | -48.6396* | 6.9682 |
| | Hs plus | .054705* | .018631* | .032898* | 20.6240* | 23.2839 | 21.9475* |
| | University | .182460* | .036432* | .139129* | 24.0622* | 49.1912* | 20.6292* |
| | Excellent (health) | .064452* | .011265* | .047862* | N/A | N/A | N/A |
| | Very good (health) | .050050* | .005061 | .042043* | N/A | N/A | N/A |
| | Fair (health) | -.038343* | -.000812 | -.036459* | N/A | N/A | N/A |
| | Poor (health) | -.084709* | -.013266* | -.066500* | N/A | N/A | N/A |
| | Short (duration) | .049677* | .015422* | .032944* | .7204 | 8.6772 | .3189 |
| | Long (duration) | .093257* | .019359* | .067158* | 10.3600 | 25.5999 | 11.0225 |
| | Foreign | -.069128* | -.016955* | -.045616* | N/A | N/A | N/A |
| **Attitudes & Preferences** | Male | -.022010* | -.026732* | .010693 | 37.1731* | -26.7283 | 29.0254* |
| | Small (city) | .020153* | -.005035* | .024946* | -2.9266 | -9.7261 | -8.5331 |
| | Large (city) | -.049100* | -.004518 | -.043376* | 3.4206 | 23.5061 | -3.5901 |
| | Very religious | .079153* | .006194 | .065988* | 31.1797* | -3.8062 | 28.3617* |
| | Not very religious | -.036469* | -.004939 | -.029525* | -9.7724 | -21.4863 | -8.4728 |
| | Not at all religious | .037402* | -.003951 | -.031784* | 10.1157 | -22.6134 | 12.3442 |
| | Protestant | .068266* | .008305 | .054176* | -8.4556 | -5.4423 | -12.5717 |
| | Catholic | -.001452 | .005732 | -.008919 | -11.0613 | -.2508 | -11.9689 |
| | United | .045326* | .002847 | .037970* | -6.6595 | -6.9250 | -10.3032 |
| | Other | .068187* | -.001827 | .065689* | 16.4229 | -11.6090 | 11.7101 |
| | BC | .008566 | -.006838 | .017997 | 13.0698 | -17.3372 | 12.8709 |
| | Alberta | .068704* | .004712 | .059141* | -11.5186 | -11.6508 | -12.5002 |
| | Saskatchewan | .103720* | -.000504 | .100787* | -20.1886* | -18.5039 | -23.4246* |
| | Manitoba | .058077* | -.005655 | .063905* | -19.0999* | -21.2029 | -22.2619* |
| | Quebec | -.044826* | -.026627* | -.010260 | 29.4150* | -23.0688 | 34.0995* |
| | New Brunswick | .001773 | -.004883 | .009216 | 13.6945 | 13.1354 | 11.6753 |
| | Nova Scotia | .012346 | .001014 | .009660 | 5.2380 | -2.8930 | 9.8409 |
| | PEI | .018290 | .003786 | .011790 | 6.3949 | 22.8640 | 11.3361 |
| | Newfoundland | -.034098* | -.001840 | -.029256* | 16.7674 | -20.2574 | 25.6529* |
| | Role model | .035354* | .008447* | .025309* | N/A | N/A | N/A |
| | Parent | .101739* | .014840* | .081046* | N/A | N/A | N/A |
| | Helped | .071205* | .006345* | .061132* | N/A | N/A | N/A |
| | Income | 7.83e-07* | 1.74e-07* | 5.06e-07 | -.0002* | -.0002 | -.0002* |
| | 2001 | -.111746* | -.008431* | -.094684* | -28.1896* | -16.86 | -28.8978* |

## Appendix II: Informal Volunteering

The table below shows the results from the Heckman 2-stage regression where the choice of whether or not to volunteer constituted the first stage, and the choice of hours the second stage. Variables significant at the 5% level are marked with an asterick (*). Note that informal hours had to use the more limited 1998 GSS data. Variables not included in the regression are marked N/A.

| Category | Variable | All Participation (dF/dX) | Health Participation (dF/dX) | Non-Health Participation (dF/dX) | Weekly Health Hours (GSS) |
|---|---|---|---|---|---|
| **Time** | Married | .0427777* | .0246449 | .0165391 | .4082047 |
| | Kids05 | -.0210513 | -.0468035* | .0261507 | -1.5779440* |
| | Full-time | .0148925 | .0486834 | -.0344630 | -2.4589570* |
| | Part-time | -.0179053 | .0073979* | -.0209174 | -2.7437840* |
| | Unemployed | .0028010 | -.0144500 | .0231816 | N/A |
| | | | | | |
| **Knowledge & Ability** | Age | .0024075 | .0109181* | -.0074434* | .3082608* |
| | Age2 | -.0000536* | -.0001076* | .0000420 | -.0025324 |
| | Kids618 | -.0026433 | .0075125 | -.0098240 | N/A |
| | No hs | -.0437700* | -.0679676* | .0063491 | 2.9901570* |
| | Hs plus | .0324327* | .0153008 | .0143915 | .1936728 |
| | University | .0432912* | -.0026536 | .0406711* | .3211914 |
| | Excellent (health) | -.0037242 | -.0172163 | .0129004 | N/A |
| | Very good (health) | -.0241870 | -.0183365 | -.0063244 | N/A |
| | Fair (health) | -.0504041* | -.0017822 | -.0479109* | N/A |
| | Poor (health) | -.2304777* | -.0622427* | -.1583738* | N/A |
| | Short (duration) | .0261812 | -.0195511 | .0427968* | N/A |
| | Long (duration) | .0399971* | -.0033823 | .0402550* | N/A |
| | Foreign | -.0716919* | -.0549501* | -.0184284 | N/A |
| **Attitudes & Preferences** | Male | -.0251090* | -.0832306* | .0601175* | -1.5188160* |
| | Small (city) | 1.20e-07 | 5.78e-08 | 9.66e-08 | N/A |
| | Large (city) | -.0240439 | -.0110211 | -.0161098 | N/A |
| | Very religious | .0137636 | .0072182 | .0054820* | 1.2185650 |
| | Not very religious | -.0264111 | .0176111* | -.0484889 | 1.1131120 |
| | Not at all religious | -.0523928* | -.0780717* | .0279003 | .7868165 |
| | Protestant | .0484777* | -.0588729 | .0124168 | .6268116 |
| | Catholic | .0482400* | .0185538* | .0329187* | -.1007760 |
| | United | .0698035* | .0379367* | .0392247 | N/A |
| | Other | .0669333* | .0581551* | .0217223 | N/A |
| | BC | .0546487* | .0606693 | .0048409* | -.5541977 |
| | Alberta | .0470798 | .0023797 | .0446172 | .3445920 |
| | Saskatchewan | .0137897* | -.0160751 | .0258004* | -.3173944 |
| | Manitoba | .0653035* | .0118580 | .0440937 | -.8096682 |
| | Quebec | .0609820 | .0226394* | .0327331 | 1.0536070 |
| | New Brunswick | .0094138 | .0437930 | -.0310394 | -.1971549 |
| | Nova Scotia | -.0327748 | -.0122039 | -.0194870 | .9437817 |
| | PEI | .0039184 | -.0008190 | .0008608 | 1.4906920 |
| | Newfoundland | -.0049305 | .0045978 | -.0164717 | 2.5885270 |
| | Role model | -.0127073* | -.0126907* | -.0062335 | N/A |
| | Parent | .0776030* | .0770133* | .0057676 | N/A |
| | Helped | .0620080* | .0466771* | .0147646 | N/A |
| | Income | 1.20e-07 | 5.78e-08 | 9.66e-08 | N/A |
| | 2001 | .0552466* | .0581046* | -.0005488 | N/A |

# Appendix III: Regression by Sex

| Category | Variable | Male Formal Participation | Female Formal Participation | Male Formal Hours | Female Formal Hours | Male Informal | Female Informal |
|---|---|---|---|---|---|---|---|
| **Time** | Married | .0673522* | .0280989* | -1.765408 | -10.10469 | .0537901* | .0385891* |
| | Kids05 | -.0592622* | -.0877229* | -7.05735 | -6.492375 | -.0064022 | -.0318562 |
| | Full-time | -.0553083* | -.0850072* | -27.76731 | -26.56566* | -.0563916* | .0174559 |
| | Part-time | .024885 | .0277021 | -31.36503 | -5.835185 | .0083808 | .0292599 |
| | Unemployed | .0065119 | -.0058062 | -39.52493* | 22.56033 | -.0373137 | .0366788 |
| | | | | | | | |
| **Knowledge & Ability** | Age | -.0026773 | .0031265 | .0556253 | -.869895 | .0006582 | .0048241* |
| | Age2 | .0000138 | -.0000548* | .0176264 | .0295675 | -.0000439 | -.0000732* |
| | Kids618 | .0743245* | .0760975* | N/A | N/A | .0108812 | -.0191618 |
| | No hs | -.0843785* | -.0835479* | -24.4386 | 35.15497 | -.0382498 | -.0427497 |
| | Hs plus | .0530712* | .0572083* | 44.11978* | 28.75137* | .0384237 | .0269231 |
| | University | .1698907* | .1959047* | 42.76894* | 41.34898* | .0800075* | .0018996 |
| | Excellent (health) | .0776251* | .0498674* | N/A | N/A | -.0119865 | .0021893 |
| | Very good (health | .0524328* | .0476155* | N/A | N/A | -.0252668 | -.0225935 |
| | Fair (health) | -.0129104 | -.0575977* | N/A | N/A | -.0170806 | -.0765145* |
| | Poor (health) | -.0631339 | -.1059271 | N/A | N/A | -.2520565* | -.2103556* |
| | Short (duration) | .0359062 | .0630448* | -1.088241 | 24.96326 | .03097 | .0187991 |
| | Long (duration) | .0887207* | .0971214* | 9.705249 | 20.00398* | .0388926 | .0399076* |
| | Foreign | -.0775308* | -.062171* | N/A | N/A | -.0767267* | -.0743524* |
| **Attitudes & Preferences** | | | | | | | |
| | Small (city) | .0065222 | .0320729* | -3.021212 | -1.711542 | .0146433 | .0108683 |
| | Large (city) | -.0573321* | -.0391311* | -4.029152 | -11.01001 | -.0498201* | -.0012485 |
| | Very religious | .0606303* | .0920421* | 49.53664* | 33.80795* | -.0479871 | -.0140211 |
| | Not very religious | -.0401712* | -.0344965* | -2687932* | 8.953859 | -.0636513* | -.0413074* |
| | Not at all religious | -.0402857* | -.0341017 | -1.008926 | 14.97758 | -.0725989* | -.0195168 |
| | Protestant | .0680622* | .0643948* | 2.316076 | -1.241918 | .0315055 | .0618478* |
| | Catholic | -.0074548 | .0032587 | -5.225637 | .4557984 | .1058312* | .0364362 |
| | United | .075963* | .0141694 | -21.83382 | -5.452643 | .0766728* | .0585362* |
| | Other | .0699026* | .0630422* | 40.247 | 44.81072* | .0594952 | .0556341* |
| | BC | .0069707 | .011196 | 15.89141 | 20.986 | .0611402* | .0315673 |
| | Alberta | .0729454* | .0694792* | -14.5052 | -15.98681 | .0257149 | -.0014901 |
| | Saskatchewan | .1074924* | .1025561* | -12.55831 | -23.80742* | .0605228* | .0709857* |
| | Manitoba | .0448691* | .0740361* | -24.93081* | -25.92706* | .0728638* | .0482627* |
| | Quebec | .0018076 | -.0899113* | 22.29064 | 7.812039 | -.0030917 | .0184763 |
| | New Brunswick | -.0009285 | .0076524 | 18.05742 | 18.3836 | -.0671151* | -.008434 |
| | Nova Scotia | .0230165 | .0053593 | 20.08422 | -6.956592 | .0120421 | -.0040775 |
| | PEI | .022171 | .0163466 | 18.73315 | -10.45135 | -.0578637 | .0399554 |
| | Newfoundland | -.0595864* | -.0046618 | 42.96173 | 2.085318 | -.0180917 | -.0102273 |
| | Role model | .0369562* | .0326088* | N/A | N/A | .0747582* | .079332* |
| | Parent | .0805529* | .1228052* | N/A | N/A | .0691339* | .0573625* |
| | Helped | .0827264* | .0591863* | N/A | N/A | .1041921* | .1133565* |
| | Income | 7.48e-07* | 8.25e-07* | -.0003583* | -.0001995 | 1.[illegible]e-07 | 1.48e-07 |
| | 2001 | -.1059797* | -.1139871* | -24.1906* | -20.87872* | .0646626* | .0414915* |

** = significant at the 5% level*

*Wald statistic testing joint Ho: $\beta_{male} = \beta_{female}$ for all $\beta$*

*Formal:* $X^2 = 100.24$

$Prob > X^2 = 0.0000$ *(reject Ho at 1% significance level)*

*Informal:* $X^2 = 61.35$

$Prob > X^2 = 0.0165$ (reject Ho at 2% significance level)

# Appendix IV: Regression by Time

| Category | Variable | 1997 Formal Participation | 2000 Formal Participation | 1997 Formal Hours | 2000 Formal Hours | 1997 Informal Participation | 2000 Informal Participation |
|---|---|---|---|---|---|---|---|
| **Time** | Married | .0174019 | .0703322* | -7.855997 | -8.460566 | .0444632* | .0381621* |
| | Kids05 | -.0711465* | -.0716937* | -12.41307 | 6.9302202 | -.0100899 | -.0310347 |
| | Full-time | -.0713255* | -.0765699* | -38.90378* | -34.27152 | -.0209996 | -.0778694 |
| | Part-time | .0478984* | .0109502 | -28.35996* | -23.31211 | .0364317 | -.0766125 |
| | Unemployed | -.0226187 | .0023142 | -42.31471* | -26.06631 | .0254723 | -.0756745 |
| **Knowledge & Ability** | Age | .0000452 | .0005424 | 1.36115 | -1.817162 | .0069751* | -.0023311 |
| | Age2 | -.0000199 | -.0000244 | -.00194 | .0475819 | -.0001044* | 1.05e-06 |
| | Kids618 | .101534* | A | N/A | N/A | -.0144252 | A |
| | No hs | -.0880257* | -.0746106* | -23.04155 | 46.96196 | -.0782549* | -.0047531 |
| | Hs plus | .0797119* | .0245055 | 38.95717* | 30.13543* | -.0046461 | .0670625* |
| | University | .2367463* | .1264717* | 43.04894* | 40.87573* | .0241591 | .0635455* |
| | Excellent (health) | .0638933* | .0587421* | N/A | N/A | -.0004399 | -.0063642 |
| | Very good (health | .0486825* | .0528554* | N/A | N/A | -.0025546 | -.0456849* |
| | Fair (health) | -.017968 | -.050808* | N/A | N/A | -.0403021 | -.059898* |
| | Poor (health) | -.0748988* | -.090826* | N/A | N/A | -.1491152* | -.2836436* |
| | Short (duration) | .0356573 | .0630256* | 16.83008 | 8.981881 | .0111475 | .0434752 |
| | Long (duration) | .0969699* | .0888657* | 24.21241* | 6.333692 | .0386128* | .0480632* |
| | Foreign | -.0902284* | -.0372106 | N/A | N/A | -.111373* | -.0346346 |
| **Attitudes & Preferences** | Male | -.0139263 | -.028924* | 33.70776* | 27.62473* | -.0317454* | -.0159072 |
| | Small (city) | .0287422* | .0115757 | -3.336087 | -2.970258 | .0177201 | .0105763 |
| | Large (city) | -.0380717* | -.0533419* | -6.698827 | -9.567467 | -.0457921* | .0018912 |
| | Very religious | .0890147* | .0731198* | 41.87534* | 35.22545* | -.0220529 | -.0292859 |
| | Not very religious | -.0527833* | -.0229363 | -5.098856 | -13.82866 | -.086926* | -.0212662 |
| | Not at all religious | -.0342923* | -.0389819* | 6.706229 | 5.148365 | -.0595824* | -.0339625 |
| | Protestant | .0887132* | .0520385* | 1.033303 | -3.591531 | .0781023* | .0458983* |
| | Catholic | .0091794 | -.0118848 | .0882778 | -5.583169 | .0722065* | .0659674* |
| | United | .0924665* | -.0476662 | -3.586453 | -41.84093* | .0608476* | .052416 |
| | Other | .0840405* | A | 46.47273* | A | .0557951* | A |
| | BC | .0015354 | .015371 | 25.37577* | 12.74512 | .059707* | .0348194 |
| | Alberta | .0364414* | .0971678* | -.1846061 | -28.03306 | -.0487148* | .0615327* |
| | Saskatchewan | .0784739* | .1255375* | -13.45618 | -25.74213 | .0453241* | .0702179* |
| | Manitoba | .0354588 | .0822788* | -13.51993 | -38.3634* | .0261087 | .0789819* |
| | Quebec | -.0618044* | -.0252184 | 21.70723 | 4.059075 | -.0544432* | .0588344* |
| | New Brunswick | -.0185611 | .0183239 | 20.58756 | 12.72673 | -.0685657* | -.0035865 |
| | Nova Scotia | -.00989 | .028861 | .4095572 | 6.314769 | -.0253465 | .0195578 |
| | PEI | -.0240868 | .0525093 | -11.30911 | 14.97033 | -.0851389* | .0503608 |
| | Newfoundland | -.0633197* | -.0095295 | -4.644269 | 46.25247 | -.093105* | .0461708 |
| | Role model | .0347567* | .036256* | N/A | N/A | .0605814* | .09413357* |
| | Parent | .1086314* | .0953401* | N/A | N/A | .0990446* | .0266369 |
| | Helped | .0758811* | .066317* | N/A | N/A | .1106054* | .0992222* |
| | Income | 5.04e-07* | 1.22e-06* | -.0001297 | -.000494* | 2.85e-07 | -1.39e-07 |

** = significant at the 5% level*

*A = omitted due to collinearity*

*Wald statistic testing joint Ho: $\beta_{1997} = \beta_{2000}$ for all $\beta$*

*Formal:* $X^2 = 67.47$

*Prob > $X^2$ = 0.0031 (reject Ho at 1% significance level)*

*Informal:* $X^2 = 102.74$

*Prob > $X^2$ = 0.0000 (reject Ho at 1% significance level)*

## Appendix V: Independent Variables

Below is a list of all of the independent variables used in the regressions. The category will be listed with all of the variables that measure a given category below it. In the case of dummy variables, the base case that is excluded from the regression will be in parenthesis.

*Time Variables*

1. Marital Status
    a. (single) – includes never married, divorced, widowed
    b. married
2. Children Aged 0-5
    a. (none)
    b. kids05 - at least one child aged 0-5 is in the house
3. Labour Force Status
    a. (outside labour force)
    b. full-time
    c. part-time
    d. unemployed

*Knowledge and Ability Variables*

1. Age
    a. age - age in individual years
    b. age2 - age*age
2. Kids 6-18
    a. (none)
    b. kids618 - at least one child aged 6-18 is in the house
3. Education
    a. no hs - never attended high school
    b. (some hs) - attended high school but did not graduate
    c. hs plus - graduated high school but never attended university
    d. university – attended university
4. Health
    a. excellent
    b. very good
    c. (good)
    d. fair
    e. poor
5. Duration
    a. short – lived in community for less than 2 years
    b. (medium) – lived in community for 2-6 years
    c. long – lived in community for more than 6 years
6. Birth Country
    a. (Canada)
    b. Foreign – born outside of Canada

*Social Attitude and Preference Variables*

1. Sex
    a. male
    b. (female)
2. City Size
    a. small – less than 15 000 people
    b. (medium sized) – 15 000 to 500 000
    c. large – greater than 500 000 people
3. Religious Devotion
    a. very religious
    b. (somewhat religious)
    c. not very religious
    d. not at all religious
4. Religion
    a. (none)
    b. Catholic
    c. Protestant
    d. United – member of United Church
    e. other
5. Province
    a. BC – British Columbia
    b. Alberta
    c. Saskatchewan
    d. Manitoba
    e. (Ontario)
    f. Quebec
    g. New Brunswick
    h. Nova Scotia
    i. PEI – Prince Edward Island
    j. Newfoundland
6. Youth Experience
    a. role model – while individual was young, saw a role model volunteer
    b. parent - while individual was young, saw a parent volunteer
    c. helped - while individual was young, was helped by a volunteer
7. Income
8. Time
    a. (1997)
    b. 2000

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# Voluntary Health Organizations in Canada: Public Involvement and Support

## Results from the 2000 National Survey of Giving, Volunteering and Participating

Canadian Centre for Philanthropy ™
*Le Centre canadien de philanthropie* MC

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## Results from the 2000 National Survey of Giving, Volunteering and Participating

**David M. Lasby**

**Don K. Embuldeniya**

**March 8, 2002**

Canadian Centre for Philanthropy
425 University Avenue, Suite 700
Toronto, Ontario, M5G 1T6
Telephone: (416) 597-2293, Fax: (416) 597-2294
www.ccp.ca
www.nonprofitscan.org
www.nsgvp.org

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# Table of Contents

Executive Summary ..... 73

Giving to Voluntary Health Organizations ..... 73

Summary of Key Findings about Donors ..... 74

Volunteering for Voluntary Health Organizations ..... 75

Summary of Key Findings about Volunteers ..... 75

Introduction ..... 76

Charitable Giving to Voluntary Health Organizations in Canada ..... 77

Financial Support for Voluntary Health Organizations ..... 79

Provincial Variations in Giving to Voluntary Health Organizations ..... 80

Who are Canada's Health Donors? ..... 82

Personal and Economic Characteristics ..... 82

Changes from 1997 to 2000 ..... 85

Who Gives the Most? ..... 85

Who are the Top Health Donors? ..... 86

The Role of Religion ..... 88

Support of Health Donors for Other Causes ..... 89

Donating to Health Organizations: Motivations and Barriers ..... 92

How Voluntary Health Organizations Attract Financial Donations ..... 94

Volunteering for Health Organizations ..... 96

Volunteer Support for Health Organizations ..... 97

Provincial Variations in Volunteering for Health Organizations ..... 98

Who Are Canada's Health Volunteers? ..... 99

Personal and Economic Characteristics ..... 99

Changes from 1997 to 2000 ..... 102

Who Contributes the Most Volunteer Hours? ..... 102

Who are the Top Health Volunteers? ..... 103

The Role of Religion ..... 106

Support of Health Volunteers for Other Causes ..... 107

Volunteering for Health Organizations: Motivations and Barriers.....109
How Volunteers Became Involved in Health Organizations.....111
What Health Volunteers Do.....112

Conclusion.....114

Appendix A: Tables and Figures, 1997.....116

# List of Figures

Figure 1: Percentage of Donations and Percentage of Total Donation Value by Organization Type, 2000 ....80

Figure 2: Percentage of Canadians Who Donated to Health Organizations by Province, 2000....81

Figure 3: Average Annual Donation to Voluntary Health Organizations by Province, 2000....81

Figure 4: Concentration of Monetary Support for Voluntary Health Organizations, 200086

Figure 5: Percentage of Donations and Percentage of Total Donation Value by Request Type, 2000 ....95

Figure 6: Percentage of Volunteer Events and Percentage of Total Volunteer Hours by Organization Type, 2000 ....98

Figure 7: Percentage of Canadians who Volunteered for Health Organizations by Province, 2000 ....98

Figure 8: Average Number of Hours Volunteered Annually to Health Organizations by Province, 2000 ....99

Figure 9: Concentration of Volunteer Support for Health Organizations, 2000....103

Figure 10: Percentage of Volunteer Events and Percentage of Total Volunteer Hours by Recruitment Method, 2000 ....112

Figure 11: Volunteer Activities Undertaken by Health Volunteers, 2000 and 1997....113

Figure A.1. Percentage of Donations and Percentage of Total Donation Value by Organization Type, 1997 ....116

Figure A.2. Percentage of Canadians Who Donated to Health Organizations by Province, 1997....116

Figure A.3: Average Annual Donation to Voluntary Health Organizations by Province, 1997....117

Figure A.4: Concentration of Monetary Support for Voluntary Health Organizations, 1997.....117

Figure A.5: Percentage of Donations and Percentage of Total Donation Value by Request Type, 1997 .....118

Figure A.6: Percentage of Volunteer Events and Percentage of Total Volunteer Hours by Organization Type, 1997 .....119

Figure A.7: Percentage of Canadians who Volunteered for Health Organizations by Province, 1997 .. .....119

Figure A.8: Average Number of Hours Volunteered Annually to Health Organizations by Province, 1997 .....120

Figure A.9: Concentration of Volunteer Support for Health Organizations, 1997Figure A.10: Percentage of Volunteer Events and Percentage of Total Volunteer Hours by Recruitment Method, Health Organizations, 1997 .....121

Figure A.10: Percentage of Volunteer Events and Percentage of Total Volunteer Hours by Recruitment Method, Health Organizations, 1997 .....122

# List of Tables

Table 1: Donation Rate, Total Amount Donated and Average Donation by Organization Type, 2000 ..... 78

Table 2: Number of Donors, Donation Rate, Number of Donations, Amounts Donated and Average Donation All Organizations and Health Organizations, 2000 and 1997 ..... 79

Table 3: Demographic Characteristics of Voluntary Health Organization Donors, 1997 and 2000 ..... 84

Table 4: Demographics of Top and Other Voluntary Health Donors, 2000 and 1997 ..... 87

Table 5: Religion Related Characteristics of Voluntary Health Organization Donors, 1997 and 2000 ..... 89

Table 6: Average Number of Organizations Supported by Donor Type, 2000 and 1997 .90

Table 7: Support for Organizations, Health Donors and Regular donors, 2000 ..... 91

Table 8: Allocation of Donation Amounts by Organization Type, Health Donors and Regular donors, 2000 ..... 92

Table 9: Motivations for Donating, Health Donors and Non-Health Donors, 2000 and 1997 ..... 93

Table 10: Barriers to Donating More, Health and Non-Health Donors, 2000 and 1997 ... 94

Table 11: Volunteer Rate, Total Hours Volunteered and Average Hours Volunteered by Type of Organization, 2000 ..... 96

Table 12: Volunteer Rate, Total and Average Hours Volunteered, All Organizations and Health Organizations, 2000 and 1997 ..... 97

Table 13: Demographic Characteristics of Voluntary Health Organization Volunteers, 1997 and 2000 ..... 101

Table 14: Demographic Characteristics of Top and Other Health Volunteers, Voluntary Health Organizations, 2000 and 1997 ..... 105

Table 15: Religion Related Characteristics of Health Volunteers, 1997 and 2000 ..... 106

Table 16: Religion Related Characteristics of Top and Other Health Volunteers, Voluntary Health Organizations, 2000 and 1997 .....107

Table 17: Average Number of Organizations Supported by Volunteer Type, 2000 and 1997.....107

Table 18: Rate of Volunteering by Organization Type, Health Volunteers and Regular Volunteers, 2000 .....108

Table 19: Allocation of Volunteer Hours, Health Volunteers and Regular Volunteers, 2000.....109

Table 20: Motivations for Volunteering, Health Volunteers, 2000 and 1997 .....110

Table 21: Barriers to Volunteering More, Health and Non-Health Volunteers, 2000 and 1997.....111

Table A.1: Donation Rate, Total Amount Donated and Average Donation by Organization Type, 1997 .....123

Table A.7: Support for Organizations, Health Donors and Regular Donors, 1997 .....123

Table A.8: Allocation of Donation Amounts by Organization Type, Health Donors and Regular Donors, 1997 .....124

Table A.11: Volunteer Rate, Total Hours Volunteered and Average Hours Volunteered by Type of Organization, 1997 .....124

Table A.18: Rate of Volunteering by Organization Type, Health Volunteers and Regular Volunteers by Organization Type, 1997 .....125

Table A.19: Allocation of Volunteer Hours, Health Volunteers and Regular Volunteers, 1997.....125

# Executive Summary

Many people consider Canada's health care system to be a distinguishing feature of Canadian society. When Canadians think of the organizations that make up the health care system, they often think first of hospitals and other institutions such as rehabilitation facilities, nursing homes and psychiatric hospitals. But Canada's voluntary health sector also includes community health centres, crisis intervention services, public health services such as recreation and sport programs, walk-in clinics and physical therapy centres, emergency medical services, and organizations that focus on specific health issues.[1]

One way that Canadians demonstrate their support for these voluntary health organizations is through voluntary effort – by donating money and time to health organizations. This support has become increasingly important as the health care system continues to undergo change. Hospital restructuring has taken place, or is taking place, in most provinces. Hospitals have shortened inpatient stays and have come to rely more on community supports for newly discharged patients. Community health organizations have felt the pressure to provide more care for these patients and for a growing number of frail seniors. Organizations that serve and support those with specific illnesses are highly dependent on contributions of time and money. Reliance on voluntary effort will likely grow as governments implement changes to the financing of the health sector in Canada.

This report provides information about Canadians who donate money and volunteer time to voluntary health organizations. It updates a previous report, *Voluntary Health Organizations in Canada: Public Involvement and Support,* which was based on data from the 1997 National Survey of Giving Volunteering and Participating (NSGVP). [2] The current report compares the 2000 and 1997 data to give an indication of trends in giving and volunteering to voluntary health organizations in Canada.[3]

## Giving to Voluntary Health Organizations

Health organizations are the most broadly supported type of voluntary organization in Canada. More than half of Canadian donors (54%) made at least one donation to a voluntary health organization during 2000. These donors gave an average of $74 each, for a total of $963 million. This is a substantial increase from 1997, when 51% of Canadian donors gave an average of $62 each for a total of just under $748 million.

---

[1] Note that the definition of the voluntary health sector used in this report does not include medical research, which is considered part of the education and research sector, although it does include special-focus health organizations, such as the Kidney Foundation of Canada and The Arthritis Society.

[2] *Voluntary Health Organizations in Canada: Public Involvement and Support* can be found at http://www.nsgvp.org/n-r4-ca-1.htm.

[3] Where not present in the body of the text, figures and tables presenting 1997 data can be found in Appendix A.

Voluntary health organizations received almost 41% of the total number of donations and 20% of the total amount donated by Canadians in 2000. Both the percentage of Canadians who gave to health organizations and the average annual health donation increased in almost every province between 1997 and 2000.

While broadly typical of Canadians as a whole, health donors were more likely to be well-educated, employed (particularly full-time) and to have higher than average household incomes. They were also more likely than other donors to give because of a personal connection to the work of the organizations they supported. These characteristics suggest an ability and a willingness to give that could be further tapped by voluntary health organizations.

The 2000 data also points to some areas that may be of concern to voluntary health organizations. As in 1997, the bulk of the money donated to health organizations came from a relatively small number of Canadians. The 25% of Canadians who donated more than $69 during the year to health organizations accounted for 76% of the total value of health donations. Voluntary health organizations may want to consider how they can broaden this base of support. They may also want to re-examine the ways in which they solicit donors and address donors in uncertain economic times. Almost half of health donors (48%) said that they did not give more because they did not like the way in which requests for donations were made. An equal number (48%) said they preferred to save their money for their own future needs.

**Summary of Key Findings about Donors**

- Health donors tended to be over the age of 35, female, well-educated, employed, affiliated with a religious faith and to have higher than average household incomes.
- The overwhelming majority of health donors (93%) made a donation to help a cause in which they personally believed or because they or someone they knew were personally affected by the cause (76%).
- The percentage of Canadians who donated to health organizations was highest in Newfoundland (71%) and lowest in Quebec (42%). The average annual health donation ranged from a high of $90 in Ontario to a low of $35 in Newfoundland.
- Health donors gave to fewer types of organizations, on average, than any other type of donor. They were more likely to support arts, culture and recreation, and social services organizations and less likely to support international and religious organizations.
- The most common methods of making health donations were door-to-door solicitation (24% of the number of donations), paying to attend a sponsored event (20%) and responding to a mail request (17%). Some of these methods brought in more money than others. The most lucrative methods were mail requests (24% of the total value of health donations), in memoriam gifts (22%) and paying to attend a sponsored event (13%).

# Volunteering for Voluntary Health Organizations

Volunteer support is vital to most health organizations. While the percentage of Canadians who volunteered for health organizations declined slightly (from 5% in 1997 to 4.5% in 2000), health volunteers contributed more hours each on average (87 hours in 2000, up from 73 hours in 1997). They volunteered a total of just over 96.4 million hours, up from 92.6 million hours in 1997. Health organizations received 13% of the total number of volunteering events and 9% of the total number of volunteer hours in 2000. This is similar to the 1997 figures.

Personal connection was a strong motivator for health volunteers. The vast majority of health volunteers (96%) got involved primarily out of a personal belief in the cause the organization supported or because they, or someone they know, were personally affected by the cause (75%). Indeed, health volunteers were markedly more likely than non-health volunteers to cite this personal connection.

The personal touch also drew people to volunteering. More health volunteers got involved as a result of being asked by a health organization than in any other way (41%). Another 12% got involved because they were asked by a friend. Nearly one in five (18%) got involved by approaching the organization on their own.

While the dedication and personal commitment of health volunteers was strong, there are a couple of areas that may be of concern to voluntary health organizations. A relatively small number of health volunteers did most of the work. The 25% of Canadians who volunteered 72 hours or more annually to health organizations accounted for 85% of the total number of volunteer hours. Health volunteers, like other volunteers, are increasingly time-stressed. More than three-quarters (75%) of health volunteers cited lack of time as a barrier to increased participation. This is up from 71% in 1997. Over one-third (34%) said they were unwilling to make a year-round commitment. Health organizations may need to restructure their volunteer opportunities to accommodate volunteers who have only a limited amount of time to give.

**Summary of Key Findings about Volunteers**

- Health volunteers tended to be female, between the ages of 45 and 54, employed, and to have higher levels of education and higher than average household incomes.
- Health volunteers were important to the fundraising efforts of health organizations. The majority (51%) were involved in fundraising. Fewer (36%) organized or supervised events or activities and only one-quarter (26%) provided care and support, such as counseling and friendly visiting.
- The percentage of Canadians who volunteered for health organizations was highest in the Atlantic provinces (7% each in Newfoundland, PEI and Nova Scotia, 5% in New Brunswick) and lowest in Quebec (2%). The volunteer rate declined slightly between 1997 and 2000 or held steady in every province except Newfoundland, where it increased slightly (6% in 1997, 7% in 2000). Except in

Western Canada, the average number of hours volunteered annually increased from 1997 to 2000.

- Health volunteers contributed their time to more types of organizations than other volunteers. They were more likely to support social services; arts, culture and recreation; religious; and education and research organizations. They allocated the majority of their volunteer time (51%) to health organizations and, compared to all volunteers, gave much less time to other organization types.
- The most common barrier to increased participation by health volunteers was a lack of time (76%). Over one-third (34%) said they were unwilling to make a year-round commitment. Thirty percent felt that they had already made a sufficient volunteer contribution.
- More health volunteers got involved because they were asked by the organization itself than in any other way (41% of health volunteer events). The next most common ways of getting involved were approaching the organization themselves (18%) and being asked by a friend (12%).

Health donors and volunteers play an important role in financing and delivering health programs and services. Any reduction in their number could have a serious impact on health organizations. The impact could be particularly significant at a time when governments are considering changes to the financing of the health sector in Canada and reliance on voluntary effort is likely grow. Voluntary health organizations may need to reach out to more Canadians and to find ways to increase the level of support of current health donors and volunteers.

# Introduction

Canada's voluntary health sector, as defined in this report, includes organizations devoted to inpatient care such as hospitals, rehabilitation institutions, nursing homes and psychiatric hospitals; organizations devoted to outpatient care such as community mental health centres, crisis intervention services, public health services, walk-in clinics and physical therapy centres; emergency medical services; and organizations with a specific focus on a particular health issue, such as heart disease, lung disease, AIDS, geriatric care, and Amyotrophic lateral sclerosis (ALS).

Among the ways that Canadians demonstrate their commitment to our health care system is through voluntary contributions to health organizations. According to the 2000 National Survey of Giving, Volunteering and Participating (NSGVP), Canadians aged 15 and older donated over $963 million to voluntary health organizations and volunteered 96 million hours of their time. [4] The majority of Canadians (54%) made at least one

[4] The NSGVP is a joint project of the Canadian Centre for Philanthropy, Canadian Heritage, Health Canada, Human Resources Development Canada, Statistics Canada and Volunteer Canada. The survey was conducted by Statistics Canada in the Fall of 2000. Interviews were conducted with 14,724 Canadians aged 15 and older who were asked about their giving, volunteering and participating over the previous year.

donation to a voluntary health organization. One out of every five dollars donated to charitable organizations in 2000 went to voluntary health organizations. However, far fewer Canadians (4.5%) volunteered their time to voluntary health organizations. Volunteering for health organizations accounted for 9% of the total number of volunteer hours in 2000.[5]

This report provides information about the Canadians who donate money and volunteer time to voluntary health organizations. It describes the percentage of people who gave, how much they donated, their personal and economic characteristics, the degree to which they supported other causes, their motivations for giving, and the barriers they perceived to giving more. It also describes the percentage of people who volunteered for health organizations, how much time they volunteered, their personal and economic characteristics, the degree to which they volunteered for other causes, their motivations for volunteering, and the barriers they perceived to volunteering more, how they become involved and what they did as volunteers. This information may help voluntary health organizations enhance their relationships with current donors and volunteers, and expand their support among Canadians.

Data used in this report are drawn from the 2000 National Survey of Giving, Volunteering and Participating (NSGVP). Comparisons are made to the 1997 NSGVP to give an indication of trends in Canadian giving and volunteering to voluntary health organizations. Where 1997 data is not presented in the tables and figures in the main report, it can be found in the Appendix A.

# Charitable Giving to Voluntary Health Organizations in Canada

Financial support for voluntary health organizations grew between 1997 and 2000. More Canadians donated money to voluntary health organizations in 2000 than to any other type of organization. Over 13 million Canadians aged 15 and over (54%) made at least one donation to a voluntary health organization between October 1, 1999 and September 30, 2000. In comparison, only 38% of Canadians donated to social service organizations, only 19% contributed to education and research, and only 13% gave to arts and culture organizations.

[5] Canadians donated approximately $4.9 billion and volunteered just over 1 billion hours during the period covered by the 2000 NSGVP.

**Table 1: Donation Rate, Total Amount Donated and Average Donation by Organization Type, 2000**

| | Donation Rate | Total Amount Donated | Average Donation |
|---|---|---|---|
| | (%) | ($'000,000) | ($) |
| **Health** | **53.7** | **963.3** | **74** |
| Social Services | 37.6 | 502.9 | 55 |
| Religion | 32.0 | 2,417.2 | 310 |
| Education and Research | 18.7 | 152.0 | 33 |
| Philanthropic Intermediaries and Voluntarism Promotion | 14.2 | 362.8 | 104 |
| Arts, Culture and Recreation | 13.0 | 161.0 | 51 |
| Environmental | 5.0 | 92.0 | 75 |
| International | 5.0 | 166.5 | 138 |
| Law, Advocacy and Politics | 4.0 | 51.8 | 53 |
| Other | 2.0 | 41.0 | 82 |
| Development and Housing | 1.2 | 17.9 | 60 |
| Professional Associations and Unions | 0.3 | 10.4 | 142 |
| All Types / Total Donations | 78.0 | 4,938.8 | 259 |

Health donors gave an average of $74 each to voluntary health organizations, for a total of $963 million. Although this is dwarfed by donations to religious organizations, which drew a much larger average donation of $310 and received a total of $2.4 billion, it puts health organizations well ahead of any other type of organization. Social service organizations, for example, received little over half as much as health organizations ($503 million).

In 1997, health donors gave an average of $62 each to voluntary health organizations, for a total of $748 million. As in 2000, voluntary health organizations received the second largest amount donated, behind religious organizations ($2.3 billion).

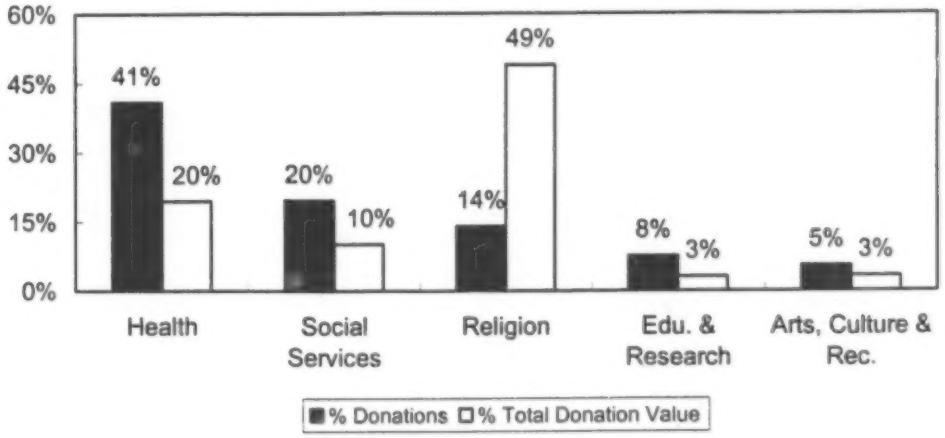
**Table 2: Number of Donors, Donation Rate, Number of Donations, Amounts Donated and Average Donation All Organizations and Health Organizations, 2000 and 1997**

| | 2000 | 1997 |
|---|---|---|
| Total Population ('000) | 24,383 | 23,808 |
| **All Organizations** | | |
| Number of Donors ('000) | 19,036 | 18,563 |
| Donation Rate (%) | 78 | 78 |
| Total Number of Donations ('000) | 70,465 | 74,413 |
| Total Amount Donated ($'000,000) | 4,938.8 | 4,435.1 |
| Average Donation ($) | 259 | 239 |
| **Health Organizations** | | |
| Number of Health Donors ('000) | 13,106 | 12,146 |
| Health Donation Rate (%) | 54 | 51 |
| Total Number of Health Donations ('000) | 28,867 | 28,338 |
| Total Amount Donated to Health Organizations ($'000,000) | 963.3 | 747.6 |
| Average Health Donation | 74 | 62 |

## Financial Support for Voluntary Health Organizations

In 2000, voluntary health organizations received more donations than any other type of organization. Voluntary health organizations also received more of the total number of donations and the total value of donations in 2000 than they did in 1997. More than four out of every ten donations (41%) were made to a voluntary health organization (Figure 1). In comparison, social service organizations received 20% of the total number of donation in 2000, religious organizations received 14%, and education and research organizations received 8%.

**Figure 1: Percentage of Donations and Percentage of Total Donation Value by Organization Type, 2000**



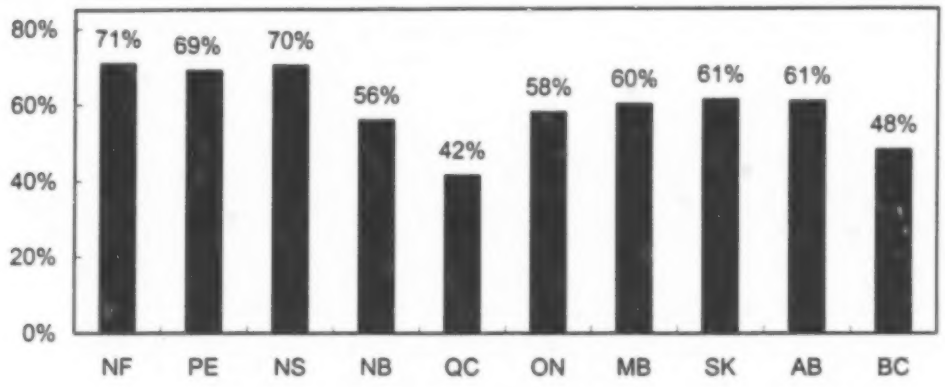

Voluntary health organizations attracted the second highest share of the total value of all donations in 2000. One out of every five donated dollars (20%) went to voluntary health organizations. Only religious organizations received more – 49% of all donated dollars in 2000. In comparison, social services organizations received 10% of the total value of donations.

Both the percentage of the number of donations and the percentage of the total value of donations made to health organizations increased between 1997 and 2000. In 2000, health organizations received 41% of the total number of donations, up from 38% in 1997; and 20% of the total value of donations, up from 17% in 1997 (Figure A.1 in Appendix A).

## Provincial Variations in Giving to Voluntary Health Organizations

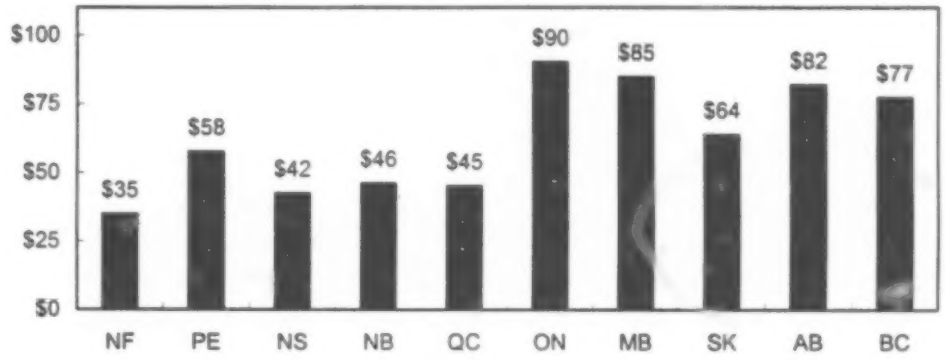
The percentage of health donors increased in all but one province in 2000. Support was highest in Atlantic Canada, with Newfoundland leading (71% of Newfoundlanders made at least one donation to a voluntary health organization during 2000), followed by Nova Scotia (70%) and Prince Edward Island (69%) (Figure 2). Saskatchewan and Alberta (61% each) were also above the national rate of 54%, as were Manitoba (60%), Ontario (58%) and New Brunswick (56%). Only in two provinces was the percentage of health donors lower than the national average: British Columbia (48%) and Quebec (42%).

**Figure 2: Percentage of Canadians Who Donated to Health Organizations by Province, 2000**




Between 1997 and 2000, the largest increases occurred in Alberta, where the percentage of health donors grew from 52% in 1997 (Figure A.2 in Appendix A) to 61% in 2000, Nova Scotia (from 63% to 70%), and Manitoba (from 53% to 60%). Only in New Brunswick did the percentage of health donors decline, from 62% in 1997 to 56% in 2000.

**Figure 3: Average Annual Donation to Voluntary Health Organizations by Province, 2000**




The average annual donation to voluntary health organizations also varied from province to province (Figure 3). Health donors in Atlantic Canada contributed less than the overall national average of $74, while health donors in Ontario and Manitoba made the largest average annual donations ($90 and $85, respectively).

The biggest growth between 1997 and 2000 occurred in Western Canada. The average annual health donation increased in Alberta from $54 in 1997 (Figure A.3 in Appendix A) to $82 in 2000, in British Columbia from ($52 to $77), in Manitoba ($61 to $85) and in Saskatchewan ($41 to $64). The largest decrease occurred in Quebec, where the average donation dropped from $58 in 1997 to $45 in 2000.

## Who are Canada's Health Donors?

### Personal and Economic Characteristics

Although broadly typical of Canadians as a whole, health donors tended to be somewhat older than the average Canadian, female, well-educated, employed (particularly full-time), affiliated with a religious faith, and to have higher than average household incomes.

*Age*

Health donors tended to be older than the average Canadian. While those over the age of 35 made up 65% of the population as a whole, they accounted for 73% of health donors (Table 3). Older Canadians made larger donations than younger Canadians. Health donors over the age of 65 gave an average of $87 to health organizations in 2000, while those aged 15 to 24 gave only $43. Because more older Canadians were health donors, and because they gave larger donations, they accounted for a larger percentage of the total value of donations to voluntary health organizations. For example, Canadians aged 65 and over accounted for 19% of the total value of health donations, but represented only 16% of health donors and 15% of the Canadian population. Conversely, those aged 15 to 24 accounted for only 6% of the total value of all health donations, but represented 10% of health donors and 17% of the Canadian population.

*Sex*

Women were more likely to be health donors than were men, making up 51% of the population, but 54% of health donors (Table 3). But women's greater participation as health donors did not translate into a larger economic role. Women health donors accounted for only 49% of the total value of all health donations.

*Education*

Canadians with a university degree were more likely than their less educated counterparts to be health donors, and made the largest average annual health donation. The university-educated made up 17% of the Canadian population in 2000, but accounted for 19% of health donors and 27% of the total value of health donations (Table 3). On average, they gave $106 to health organizations. Individuals with less than a high school education, by contrast, accounted for 27% of the population, but only 22% of health donors and 14% of

the total value of health donations. They gave an average of $49 each, less than half of their university-educated counterparts.

*Labour Force Status*

Employed Canadians were more likely to be health donors than those who were unemployed or not in the labour force. Those who were employed made up 63% of the population, but 66% of health donors (Table 3). They accounted for more than two-thirds (68%) of the total value of health donations. Canadians who were not in the labour force[6] made up 33% of the population and 31% of health donors. They accounted for 30% of the total value of health donations. The unemployed made up 4% of the population and 3% of health donors. They accounted for only 1% of the total value of health donations.

[6] "Not in the labour force" refers to those individuals who were neither employed nor unemployed, e.g., retirees, students, homemakers not looking for work, etc.

**Table 3: Demographic Characteristics of Voluntary Health Organization Donors, 1997 and 2000**

| | % Canadian Population | | % Health Donors | | Health Donor Rate (%) | | % Total Value of Health Donations | | Average Health Donation ($) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1997 | 2000 | 1997 | 2000 | 1997 | 2000 | 1997 | 2000 | 1997 | 2000 |
| **Age Group** | | | | | | | | | | |
| 15-24 Years | 17 | 17 | 9 | 10 | 27 | 33 | 5 | 6 | 38 | 43 |
| 25-34 Years | 19 | 18 | 18 | 17 | 48 | 51 | 13 | 14 | 42 | 60 |
| 35-44 Years | 22 | 21 | 24 | 24 | 56 | 61 | 28 | 26 | 72 | 80 |
| 45-54 Years | 17 | 18 | 20 | 20 | 60 | 61 | 21 | 21 | 64 | 78 |
| 55-64 Years | 11 | 11 | 13 | 13 | 61 | 61 | 14 | 14 | 68 | 80 |
| 65 Yrs and Over | 15 | 15 | 17 | 16 | 57 | 57 | 20 | 19 | 72 | 87 |
| **Sex** | | | | | | | | | | |
| Male | 49 | 49 | 45 | 46 | 47 | 50 | 45 | 51 | 62 | 81 |
| Female | 51 | 51 | 55 | 54 | 55 | 57 | 55 | 49 | 62 | 67 |
| **Marital Status** | | | | | | | | | | |
| Married / Common Law | 61 | 62 | 72 | 70 | 60 | 61 | 67 | 68 | 58 | 71 |
| Single, Never Married | 26 | 26 | 16 | 18 | 32 | 36 | 21 | 16 | 79 | 68 |
| Widow / Widower | 6 | 5 | 6 | 6 | 51 | 59 | 7 | 7 | 72 | 93 |
| Separated / Divorced | 7 | 7 | 6 | 6 | 44 | 49 | 5 | 8 | 53 | 97 |
| **Education Level** | | | | | | | | | | |
| < High School | 30 | 27 | 25 | 22 | 43 | 43 | 16 | 14 | 41 | 49 |
| High School | 19 | 20 | 18 | 20 | 49 | 55 | 17 | 20 | 57 | 75 |
| Some Post-Secondary | 10 | 9 | 9 | 9 | 47 | 54 | 8 | 9 | 53 | 75 |
| Post-Secondary Diploma | 28 | 28 | 31 | 30 | 56 | 59 | 28 | 29 | 54 | 69 |
| University Degree | 13 | 17 | 16 | 19 | 64 | 61 | 31 | 27 | 118 | 106 |
| **Labour Force Status** | | | | | | | | | | |
| Employed | 59 | 63 | 64 | 66 | 55 | 57 | 67 | 68 | 64 | 75 |
| *Full-Time* | *47* | *50* | *52* | *55* | *55* | *58* | *51* | *56* | *61* | *75* |
| *Part-Time* | *12* | *12* | *12* | *12* | *53* | *51* | *16* | *12* | *79* | *78* |
| Unemployed | 5 | 4 | 4 | 3 | 39 | 35 | 2 | 1 | 24 | 42 |
| Not in Labour Force | 35 | 33 | 32 | 31 | 46 | 50 | 32 | 30 | 61 | 72 |
| **Household Income** | | | | | | | | | | |
| < $20,000 | 24 | 13 | 16 | 9 | 34 | 38 | 10 | 6 | 40 | 45 |
| $20,000-<$40,000 | 25 | 26 | 24 | 24 | 50 | 49 | 16 | 16 | 41 | 50 |
| $40,000-<$60,000 | 23 | 23 | 24 | 22 | 54 | 53 | 19 | 21 | 49 | 69 |
| $60K-<$100K | 21 | 25 | 25 | 29 | 60 | 63 | 24 | 31 | 59 | 77 |
| >$100,000 | 7 | 12 | 11 | 15 | 74 | 66 | 30 | 26 | 174 | 129 |

*Household Income*

Perhaps not surprisingly, Canadians with the highest household incomes were more likely to be health donors, accounted for a greater percentage of the total value of health donations, and made the largest average annual health donation. Individuals with household incomes of $100,000 or more accounted for 12% of the population, 15% of health donors, but 26% of the total value of health donations (Table 3). On average, they gave $129 to health organizations. At the other end of the spectrum, individuals with

household incomes of less than $20,000 made up 13% of the population and 9% of health donors, and accounted for only 6% of the total value of health donations. On average, they gave $45.

**Changes from 1997 to 2000**

Some groups accounted for a larger share of the total value of health donations in 2000 than in 1997. For example, males donated 51% of the total value of health donations in 2000, up from 45% in 1997. Health donors who were employed full-time accounted for 56% of the total value of health donations in 2000, up from 51% in 1997. Those with household incomes of between $40,000 and $60,000 accounted for 21% of the total value of health donations in 2000, up from 19% in 1997, and those with household incomes of between $60,000 and $100,000 accounted for 31%, up from 24% in 1997.

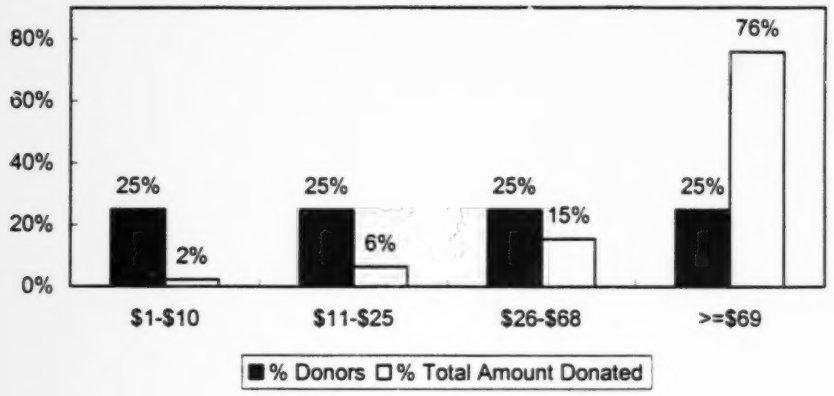
The share of total health donations declined among other groups, however. Those with university degrees accounted for nearly one-third (31%) of the total value of health donations in 1997, but only 27% in 2000. The contribution of donors with the highest incomes (equal or greater than $100,000) fell from 30% of the total value of health donations in 1997 to 26% in 2000, in spite of the fact that the percentage of Canadians in that income category increased from 7% to 12% of the population. The contribution of those with low incomes (total household incomes of less than $20,000) fell from 10% of the total value of health donations in 1997 to 6% in 2000 (this is at least partially due to the fact that the percentage of Canadians in this income category decreased from 24% in 1997 to 13% in 2000).

## Who Gives the Most?

The bulk of the money donated to voluntary health organizations came from a relatively small proportion of health donors. The top one-quarter of donors (those who contributed $69 or more) accounted for 76% of the total value of health donations in 2000 (Figure 4). The remaining three-quarters of Canada's health donors accounted for only 23% of the total amount donated. This is similar to 1997 NSGVP findings.[7]

[7] In 1997, the top quarter of health donors were those who gave $56 or more to health organizations. This lower value is due to the fact that the average donation was smaller in 1997 than it was in 2000.

**Figure 4: Concentration of Monetary Support for Voluntary Health Organizations, 2000**
**Who are the Top Health Donors?**




Because the top quarter of health donors accounted for more than three-quarters of the total value of health donations, it is essential to understand what makes them different from other health donors. Table 4 compares the top quarter of health donors to other health donors. Like health donors in general, the top quarter of health donors were more likely to be older, female, more highly educated, and to have higher household incomes.

**Table 4: Demographics of Top and Other Voluntary Health Donors, 2000 and 1997**

| | 2000 | | 1997 | |
|---|---|---|---|---|
| | % Top Health Donors | % Other Health Donors | % Top Health Donors | % Other Health Donors |
| **Age Group** | | | | |
| 15-24 Years | 5 | 12 | 5 | 10 |
| 25-34 Years | 14 | 18 | 13 | 20 |
| 35-44 Years | 24 | 24 | 23 | 24 |
| 45-54 Years | 25 | 19 | 23 | 19 |
| 55-64 Years | 13 | 13 | 15 | 12 |
| 65 Yrs and Over | 19 | 15 | 22 | 15 |
| **Sex** | | | | |
| Male | 47 | 45 | 42 | 46 |
| Female | 53 | 55 | 58 | 54 |
| **Marital Status** | | | | |
| Married / Common Law | 71 | 70 | 71 | 72 |
| Single, Never Married | 16 | 18 | 14 | 17 |
| Widow / Widower | 7 | 6 | 8 | 5 |
| Separated / Divorced | 7 | 6 | 7 | 6 |
| **Education Level** | | | | |
| < High School | 16 | 24 | 18 | 27 |
| High School | 19 | 21 | 20 | 18 |
| Some Post-Secondary | 10 | 9 | 10 | 9 |
| Post-Secondary Diploma | 29 | 31 | 31 | 31 |
| University Degree | 27 | 16 | 21 | 15 |
| **Labour Force Status** | | | | |
| Employed | 68 | 66 | 63 | 64 |
| *Full-Time* | *57* | *54* | *52* | *51* |
| *Part-Time* | *11* | *12* | *11* | *13* |
| Unemployed | 1 | 3 | 2 | 5 |
| Not in Labour Force | 31 | 31 | 35 | 31 |
| **Household Income** | | | | |
| < $20,000 | 6 | 10 | 11 | 17 |
| $20,000-<$40,000 | 18 | 26 | 18 | 26 |
| $40,000-<$60,000 | 21 | 23 | 24 | 24 |
| $60K-<$100K | 31 | 29 | 27 | 25 |
| >$100,000 | 25 | 12 | 19 | 8 |

*Age*

The majority (57%) of top health donors were 45 years of age or older, while the majority of other health donors (54%) were under the age of 45. Those aged 15 to 24 made up only 5% of top donors, but 12% of other donors, while those aged 65 and over made up 19% of top donors and only 15% of other donors.

*Sex*

The majority of both top and other health donors were women (53% and 55% respectively).

*Education*

Donors with more formal education were more likely to be top donors than those with less education. Those with a university degree made up 27% of top health donors and just 16% of other health donors, while those with less than a high school education made up 16% of top health donors, but 24% of other health donors.

*Labour Force Status*
Donors who were employed made up a slightly larger percentage of top health donors (68% vs. 66% of other donors), while those who were unemployed made up a slightly larger percentage of other health donors (3% vs. 1% of top donors).

*Household Income*

Higher percentages of top donors were from high-income households. Twenty-five percent of top health donors were from households with incomes of $100,000 or more; only 12% of other health donors fell into this category. Less than one-quarter (24%) of top health donors had household incomes of less than $40,000, while this group made up 36% of other health donors.

## The Role of Religion

Religious affiliation and participation did appear to be a significant factor among health donors in 2000 (Table 5). Individuals who claimed a religious affiliation were somewhat more likely to be health donors (74% of the population and 77% of health donors) than those without a religious affiliation. Those who attended a place of worship weekly were slightly more likely to support health organizations, (19% of the population and 20% of health donors). Those who identified themselves as "very religious" were no more likely to give to health organizations (11% of the population and 11% of health donors). When they did donate, religious individuals tended to give more to health organizations. Individuals who claimed a religious affiliation represented 74% of the population, yet accounted for 78% of the total value of health donations. Individuals who attended a place of worship weekly represented 19% of the population, yet accounted for 24% of the total value of health donations.

From 1997 to 2000, the role of religion in donation to voluntary health organizations appears to have decreased. Those who attended church services weekly accounted for 24% of the total value of health donations in 2000, down from 31% in 1997, while those who identified themselves as being very religious accounted for 10% of the total value in

2000, down from 19% in 1997. Only amongst those with a religious affiliation was the decline smaller, (78% of the total value of donations in 2000, down from 81% in 1997).

**Table 5: Religion Related Characteristics of Voluntary Health Organization Donors, 1997 and 2000**

| | % Canadian Population | | % Health Donors | | Health Donor Rate (%) | | % Total Value of Health Donations | | Average Health Donation ($) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1997 | 2000 | 1997 | 2000 | 1997 | 2000 | 1997 | 2000 | 1997 | 2000 |
| **Religious Affiliation** | | | | | | | | | | |
| No Affiliation | 25 | 26 | 22 | 23 | 45 | 49 | 19 | 22 | 54 | 72 |
| Affiliation | 75 | 74 | 78 | 77 | 54 | 57 | 81 | 78 | 64 | 75 |
| **Religious Attendance** | | | | | | | | | | |
| Weekly | 20 | 19 | 23 | 20 | 59 | 60 | 31 | 24 | 83 | 90 |
| Not Weekly | 80 | 81 | 77 | 80 | 50 | 54 | 69 | 76 | 55 | 71 |
| **Religiosity** | | | | | | | | | | |
| Very Religious | 12 | 11 | 13 | 11 | 53 | 54 | 19 | 10 | 92 | 64 |
| Not Very Religious | 88 | 89 | 87 | 89 | 51 | 55 | 81 | 90 | 57 | 76 |

## Support of Health Donors for Other Causes

Like most donors, health donors tend to support more than one type of organization. Health donors, however, donated to the smallest number of types of organization, on average, of any type of donor (Table 6).[8] Health donors donated to an average of 2.7 organization types during 2000, while donors to other types of organizations supported an average of three or more types.

[8] These other donor types were defined the same way voluntary health donors were, i.e., an arts, culture and recreation donor was defined as an individual who made at least one donation to arts, culture and recreation organizations during 2000, a social services donor was defined as someone who made at least one donation to social services organizations, etc. An individual can belong to more than one donor type at a time.

**Table 6: Average Number of Organizations Supported by Donor Type, 2000 and 1997**

| Organization Type | 2000 | 1997 |
|---|---|---|
| **Health** | **2.7** | **2.8** |
| Development and Housing | 3.8 | 3.8 |
| Professional Associations and Unions | 3.8 | 3.4 |
| Law, Advocacy and Politics | 3.7 | 3.8 |
| Other | 3.7 | 3.4 |
| International | 3.7 | 3.7 |
| Environmental | 3.5 | 3.8 |
| Arts, Culture and Recreation | 3.5 | 3.6 |
| Education and Research | 3.3 | 3.3 |
| Philanthropic Intermediaries and Voluntarism Promotion | 3.2 | 3.3 |
| Social Services | 3.0 | 3.0 |
| Religion | 3.0 | 2.9 |

Although health donors supported fewer types of organizations, their support for other causes was roughly similar to that of regular donors[9]. As Table 7 shows, however, health donors were slightly more likely to donate to some causes, such as arts, culture and recreation (18% of health donors supported this type of organization vs. 17% of regular donors) and social services (50% vs. 48%).

The average annual donation of health donors was $303 while the average annual donation of regular donors was $259. Health donors allocated nearly one-quarter (24%) of their donation dollars to voluntary health organizations (Table 8). Nearly half (47%) of health donor dollars went to religious organizations (which accounted for 49% of the money donated by regular donors). Health donors allocated nine percent of their donations to social service organizations, while regular donors allocated 10% of their donations to this organization type.

[9] Regular donors are defined as individuals who made at least one donation to any type of organization. Health donors are also regular donors (i.e. health donors are a subset of regular donors).

**Table 7: Support for Organizations, Health Donors and Regular donors, 2000**

| Organization Type | Health Donors | Regular donors |
|---|---|---|
| **Health** | **100%** | **69%** |
| Social Services | 50% | 48% |
| Religion | 40% | 41% |
| Education and Research | 24% | 24% |
| Philanthropic Intermediaries and Voluntarism Promotion | 18% | 18% |
| Arts, Culture and Recreation | 18% | 17% |
| Environmental | 6% | 6% |
| International | 6% | 6% |
| Law, Advocacy and Politics | 6% | 5% |
| Other | 3% | 3% |
| Development and Housing | 2% | 2% |
| Professional Associations and Unions | 1% | 0% |

There is significant overlap among the top supporters to these types of organizations. Nearly one-quarter (24%) of top health donors were also top social services donors (those who gave $40 or more to social services organizations) and nearly one-fifth (18%) were top religious donors (those who gave $225 or more to religious organizations). This pattern was also evident in 1997 when the top quarter of health donors were also likely to be top donors to other types of organizations.

**Table 8: Allocation of Donation Amounts by Organization Type, Health Donors and Regular donors, 2000**

| Organization Type | Health Donors | Regular donors |
|---|---|---|
| **Health** | **24.2%** | **19.5%** |
| Religion | 46.9% | 48.9% |
| Social Services | 9.2% | 10.2% |
| Philanthropic Intermediaries and Voluntarism Promotion | 6.8% | 7.3% |
| Arts, Culture and Recreation | 3.2% | 3.3% |
| International | 3.1% | 3.4% |
| Education and Research | 3.0% | 3.1% |
| Environmental | 1.6% | 1.9% |
| Law, Advocacy and Politics | 1.0% | 1.0% |
| Other | 0.5% | 0.8% |
| Development and Housing | 0.3% | 0.4% |
| Professional Associations and Unions | 0.2% | 0.2% |

## Donating to Health Organizations: Motivations and Barriers

Canadians give to charity for many reasons. The motivations reported by health donors were significantly different from those cited by non-health donors (Table 9). Health donors were markedly more likely to cite a personal connection to the cause as a motivation for giving. Seventy-six percent of health donors said they gave because they or someone they knew had been personally affected by the cause they were supporting, compared to 54% of non-health donors. Health donors were also more likely to give out of a feeling of owing something to their community (62% vs. 50% of non-health donors), a desire to help a cause in which they personally believe (93% vs. 84%), and out of compassion towards those in need (96% vs. 91%). They were somewhat less likely to report giving out of a desire to fulfill religious obligations or beliefs (30% of health donors vs. 33% of non-health donors) (Table 9).

**Table 9: Motivations for Donating, Health Donors and Non-Health Donors, 2000 and 1997**

| | 2000 | | 1997 | |
|---|---|---|---|---|
| | Health Donors | Non-Health Donors | Health Donors | Non-Health Donors |
| Feel compassion towards people in need | 96% | 91% | 96% | 92% |
| Desire to help a cause in which you personally believe | 93% | 84% | 94% | 88% |
| You or someone know is affected by cause | 76% | 54% | 73% | 50% |
| Feel you owe something to your community | 62% | 50% | 62% | 51% |
| Fulfillment of religious obligations or beliefs | 30% | 33% | 34% | 35% |
| Government will give a credit on income taxes | 13% | 13% | 12% | 8% |

These findings are more or less consistent with those in 1997. However, the personal connection increased in importance among health donors, with 76% in 2000 saying they gave because they or someone they knew was personally affected by the cause (up from 73% in 1997). Religious motivations declined. In 2000, 30% of health donors reported giving to fulfill a religious obligation, down from 34% in 1997.

There are many factors that prevent donors from giving more (Table 10). In general, health donors appeared to be markedly less affected by most of these barriers.[10] They were far less likely than non-health donors to say that it was hard to find a cause worth supporting (12% vs. 22% of non-health donors) or that they wanted to save money for future needs (48% vs. 57% of non-health donors). A note of caution, however, health donors were more likely to report that they did not like the way that requests for donations are made (48% of health donors vs. 44% of non-health donors). This barrier has increased in importance since 1997, when it was reported by 44% of health donors.

[10] Health donors were asked if any of these factors were barriers to their donating more.

**Table 10: Barriers to Donating More, Health and Non-Health Donors, 2000 and 1997**

| | 2000 | | 1997 | |
|---|---|---|---|---|
| | Health Donors | Non-Health Donors | Health Donors | Non-Health Donors |
| Do not like the way requests are made for contributions | 48% | 44% | 44% | 37% |
| Want to save money for own future needs | 48% | 57% | 52% | 58% |
| Would prefer to spend money other ways | 44% | 52% | 46% | 55% |
| Think money will not be used efficiently | 43% | 50% | 41% | 39% |
| Already give enough money directly to people | 35% | 38% | 32% | 34% |
| Give voluntary time instead of money | 26% | 28% | 27% | 31% |
| Hard to find a cause worth supporting | 12% | 22% | 9% | 16% |
| Do not know where to make a contribution | 7% | 14% | 6% | 11% |

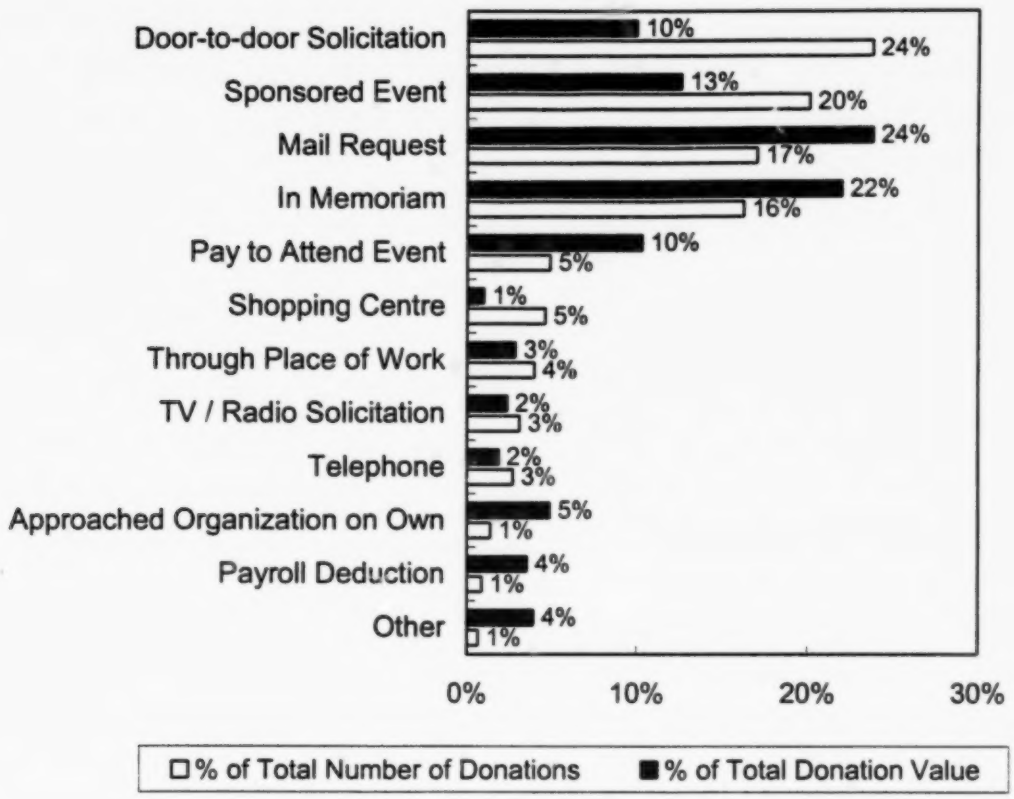
## How Voluntary Health Organizations Attract Financial Donations

Canadians donated to voluntary health organizations in a number of ways. As Figure 5 shows, the most common ways of making donations were responding to door-to-door canvassing, sponsoring an event such as a walkathon, responding to a mail request or making an in memoriam gift.

The most frequently used methods did not always bring in the most money, however. Although door-to-door solicitation attracted the largest number of donations in 2000 (24%), it accounted for only 10% of the total value of health donations (Figure 5). Similarly, sponsoring an event accounted 20% of the total number, but only 13% of the total value of health donations.

The largest share of total health donations was brought in by mail requests (17% of the total number, but 24% of the total value of health donations) and in memoriam gifts (16% of the total number, but 22% of the total value of health donations). Individuals who approached organizations on their own or who donated through payroll deduction accounted for only 1% of the total number of donations, but 5% and 4%, respectively, of the total value of health donations.

**Figure 5: Percentage of Donations and Percentage of Total Donation Value by Request Type, 2000**




There have been significant changes since 1997 in how Canadians give to health organizations. The most notable change was in door-to-door solicitation. The number of donations made though this method dropped from 33% in 1997 to 24% in 2000, while the total value of health donations attracted by this method dropped from 15% to 10%. The number of donations made by individuals paying to sponsor an event increased from 15% to 20%. This method accounted for 13% of the total value of health donations in 2000, up from 9% in 1997. The economic importance of individuals who approached voluntary health organizations on their own declined from 9% of the total value of health donations in 1997 to 5% in 2000 (Figure A.5 in Appendix A).

# Volunteering for Health Organizations

The percentage of Canadians volunteering for health organizations declined from 1997 to 2000, though the total number of hours volunteered increased. In 2000, over 1.1 million Canadians aged 15 and over volunteered at least once for a health organization between October 1, 1999 and September 30, 2000. Fewer Canadians volunteered for voluntary health organizations than for arts, culture and recreation (8.1% of Canadians), social services (7.3%), religious (5.5%) or educational (5.1%) organizations.

Health volunteers volunteered for an average of 87 hours annually, for a total of 96 million hours. These figures rank well behind those for arts, culture and recreation organizations (average 138 hours, 273 million hours total), social services (120 hours average, 214 million hours total) and religion (average 126 hours, 170 million hours total). Health volunteers are on par with volunteers for education and research (average 90 hours, 112 million hours total). Health volunteers gave an average of 87 hours of their time during the survey year. This was less than the average number of hours volunteered for almost every other organization type. Only philanthropic intermediaries and voluntarism promotion organizations received fewer volunteer hours, on average, from their volunteers (55 hours).

**Table 11: Volunteer Rate, Total Hours Volunteered and Average Hours Volunteered by Type of Organization, 2000**

| Organization Type | Volunteer Rate | Total Hours Volunteered ('000) | Average Hours Volunteered |
|---|---|---|---|
| **Health** | **4.5%** | **96,404** | **87** |
| Arts, Culture and Recreation | 8.1% | 272,595 | 138 |
| Social Services | 7.3% | 214,493 | 120 |
| Religion | 5.5% | 169,838 | 126 |
| Education and Research | 5.1% | 111,858 | 90 |
| Development and Housing | 2.0% | 51,361 | 106 |
| Law, Advocacy and Politics | 1.3% | 40,494 | 129 |
| Environmental | 1.0% | 27,213 | 108 |
| Philanthropic Intermediaries and Voluntarism Promotion | 0.9% | 12,248 | 55 |
| Professional Associations and Unions | 0.9% | 22,190 | 104 |
| Other | 0.4% | 12,255 | 117 |
| International | 0.3% | 9,866 | 121 |

In 1997, health volunteers volunteered an average of 73 hours each for voluntary health organizations, for a total of 92.6 million hours. In 2000, 170 thousand fewer volunteers each volunteered and average of 87 hours each, for a total of 96.4 million hours, an increase of almost 4 million hours since 1997.

**Table 12: Volunteer Rate, Total and Average Hours Volunteered, All Organizations and Health Organizations, 2000 and 1997**

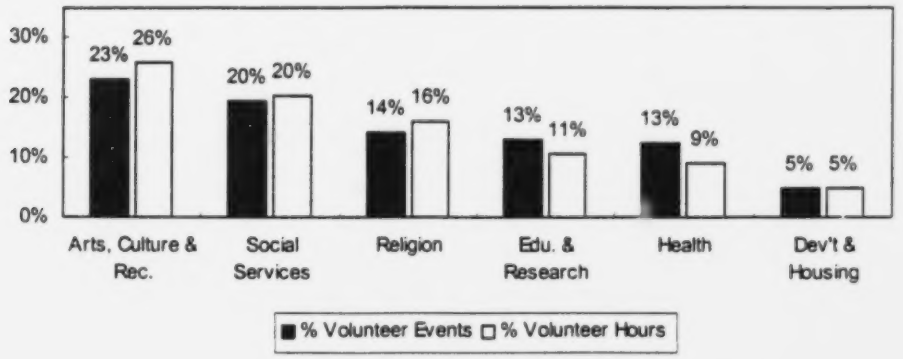
| | 2000 | 1997 |
|---|---|---|
| **Total Population ('000)** | 24,383 | 23,808 |
| **All Organizations** | | |
| Number of Volunteers ('000) | 6,513 | 7,472 |
| Volunteer Rate (%) | 26.7 | 31.4 |
| Total Hours Volunteered ('000,000) | 1,053.2 | 1,108.9 |
| Average Number of Hours | 162 | 149 |
| **Health Organizations** | | |
| Number of Health Volunteers ('000) | 1,105 | 1,275 |
| Health Volunteer Rate (%) | 4.5 | 5.4 |
| Total Hours Volunteered for Health Organizations ('000,000) | 96.4 | 92.6 |
| Average Number of Hours Volunteered for Health Organizations | 87 | 73 |

## Volunteer Support for Health Organizations

Voluntary health organizations ranked fifth both in terms of the percentage of the total number of volunteer events[11] (13%) and the percentage of the total number of volunteer hours (9%) they received during 2000 (Figure 6). Arts, culture and recreation organizations attracted much more volunteer effort (23% of events, 26% of hours), as did social services (20% of both events and hours), religious (14% of events, 16% of hours), and education and research organizations (13% of events, 11% of hours). This distribution of volunteer events and volunteer hours appears to have remained relatively constant between 1997 and 2000 (Figure A.6 in Appendix A).

[11] A volunteer event represents an involvement with an organization. It does not take into account the number of different activities performed nor the frequency, timing or duration of volunteering in that organization.

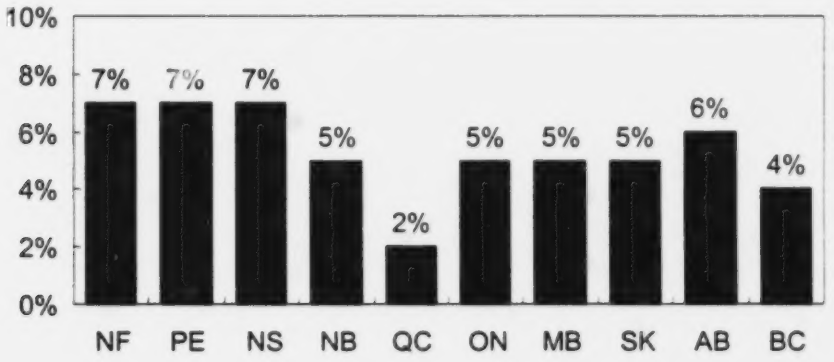
**Figure 6: Percentage of Volunteer Events and Percentage of Total Volunteer Hours by Organization Type, 2000**




## Provincial Variations in Volunteering for Health Organizations

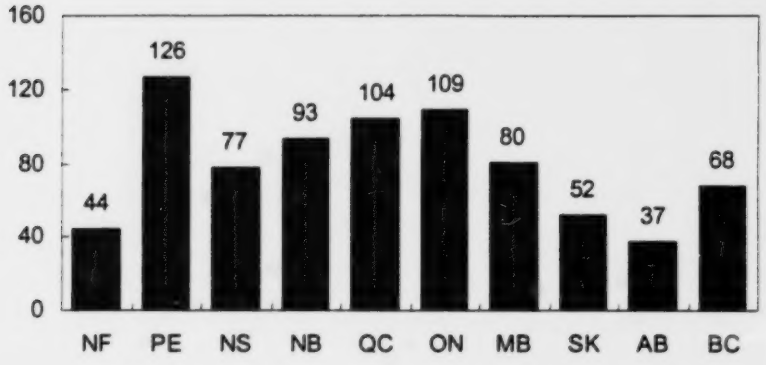
Volunteering for health organizations varied from province to province (Figure 7 and Figure 8). The percentage of Canadians who were health volunteers was highest in the Atlantic provinces (7% in each of Newfoundland, PEI and Nova Scotia) and lowest in Quebec (2%). The volunteer health rate has remained more or less constant since 1997, with the exception of Saskatchewan, where the percentage of health volunteers fell from 8% in 1997 to 5% in 2000 (Figure A.7 in Appendix A)

**Figure 7: Percentage of Canadians who Volunteered for Health Organizations by Province, 2000**



Health volunteers in Prince Edward Island contributed the most hours on average (126 hours) (Figure 8). This is a dramatic increase over the 54 hours that PEI health volunteers contributed in 1997. Albertans contributed the fewest hours on average (37 hours), a significant drop from the 54 hours they gave on average in 1997 (Figure A.8 in Appendix A). In all, the average number of hours volunteered to health organizations increased in six provinces between 1997 and 2000, and declined in the rest. No regional pattern is discernible, nor does there appear to be any predictable relationship between changes in the volunteer rate and changes in the average number of hours volunteered.

**Figure 8: Average Number of Hours Volunteered Annually to Health Organizations by Province, 2000**




## Who Are Canada's Health Volunteers?

### Personal and Economic Characteristics

As in 1997, health volunteers were generally representative of the Canadian population as a whole. However, some Canadians shouldered disproportionately more of the volunteer burden. Canadians aged 45-54, women, those with higher levels of educations, the employed and those with higher than average household incomes were more likely to be health volunteers. Table 13 presents a detailed profile of Canada's health volunteers.

*Age*

Canadians between the ages of 35 and 64 were more likely to be health volunteers compared to other age groups. However, individuals aged 65 and over accounted for a much higher percentage of the hours volunteered that did those aged 35 to 64. Those aged 65 and over accounted for 24% of the total number of hours volunteered for health organizations and gave an average of 191 hours annually.

*Sex*

Women were much more likely than men to be health volunteers (6% of women volunteered, vs. 3% of men) and made up the majority of health volunteers. Women accounted for 66% of health volunteers, 54% of total hours volunteered and gave an average of 72 hours annually. However, male health volunteers accounted for proportionally more volunteer hours than their female counterparts and gave more hours on average. Men accounted for 34% of health volunteers, but contributed 46% of the total hours volunteered and an average of 117 hours annually.

*Education*

Individuals with lower levels of education were less likely to be health volunteers than those with higher levels of education, but when they did volunteer, they contributed more hours on average. Those with less than a high-school education accounted for 27% of the population and only 14% of health volunteers, but volunteered for an average of 110 hours annually. Those with university degrees accounted for only 17% of the population, but 24% of health volunteers. They volunteered an average of 62 hours annually.

**Table 13: Demographic Characteristics of Voluntary Health Organization Volunteers, 1997 and 2000**

| | % Canadian Population | | % Health Volunteers | | Health Volunteer Rate (%) | | % Total Health Hours | | Mean Health Hours | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Age Group** | **1997** | **2000** | **1997** | **2000** | **1997** | **2000** | **1997** | **2000** | **1997** | **2000** |
| 15-24 Years | 17 | 17 | 14 | 14 | 4 | 4 | 14 | 15 | 72 | 92 |
| 25-34 Years | 19 | 18 | 15 | 14 | 4 | 4 | 10 | 17 | 48 | 107 |
| 35-44 Years | 22 | 21 | 22 | 23 | 5 | 5 | 15 | 13 | 49 | 50 |
| 45-54 Years | 17 | 18 | 24 | 24 | 8 | 6 | 24 | 15 | 74 | 55 |
| 55-64 Years | 11 | 11 | 12 | 14 | 6 | 6 | 12 | 16 | 73 | 97 |
| 65 Yrs and Over | 15 | 15 | 13 | 11 | 5 | 3 | 25 | 24 | 137 | 191 |
| **Sex** | | | | | | | | | | |
| Male | 49 | 49 | 31 | 34 | 3 | 3 | 31 | 46 | 72 | 117 |
| Female | 51 | 51 | 69 | 66 | 7 | 6 | 69 | 54 | 73 | 72 |
| **Marital Status** | | | | | | | | | | |
| Married / Common Law | 61 | 62 | 65 | 68 | 6 | 5 | 59 | 67 | 65 | 85 |
| Single, Never Married | 26 | 26 | 23 | 21 | 5 | 4 | 24 | 18 | 76 | 78 |
| Widow / Widower | 6 | 5 | 6 | 4 | 5 | 4 | 7 | 10 | 90 | 201 |
| Separated / Divorced | 7 | 7 | 6 | 7 | 5 | 4 | 10 | 5 | 121 | 64 |
| **Education Level** | | | | | | | | | | |
| < High School | 30 | 27 | 16 | 14 | 3 | 2 | 16 | 18 | 73 | 110 |
| High School | 19 | 20 | 21 | 16 | 6 | 4 | 22 | 17 | 77 | 93 |
| Some Post-Secondary | 10 | 9 | 10 | 13 | 5 | 6 | 7 | 11 | 51 | 73 |
| Post-Secondary Diploma | 28 | 28 | 34 | 32 | 7 | 5 | 33 | 36 | 70 | 99 |
| University Degree | 13 | 17 | 19 | 24 | 8 | 7 | 22 | 18 | 84 | 62 |
| **Labour Force Status** | | | | | | | | | | |
| Employed | 59 | 63 | 62 | 65 | 6 | 5 | 43 | 52 | 51 | 69 |
| *Full-Time* | *47* | *50* | *44* | *51* | *5* | *5* | *31* | *40* | *52* | *68* |
| *Part-Time* | *12* | *12* | *18* | *15* | *8* | *5* | *12* | *12* | *49* | *74* |
| Unemployed | 5 | 4 | 4 | 4 | 4 | 4 | 6 | 5 | 104 | 112 |
| Not in Labour Force | 35 | 33 | 34 | 31 | 5 | 4 | 51 | 43 | 108 | 122 |
| **Household Income** | | | | | | | | | | |
| < $20,000 | 24 | 13 | 14 | 7 | 3 | 2 | 24 | 14 | 121 | 167 |
| $20,000-<$40,000 | 25 | 26 | 21 | 21 | 5 | 4 | 25 | 25 | 87 | 103 |
| $40,000-<$60,000 | 23 | 23 | 23 | 20 | 5 | 4 | 23 | 19 | 73 | 84 |
| $60K-<$100K | 21 | 25 | 27 | 32 | 7 | 6 | 15 | 29 | 39 | 80 |
| >$100,000 | 7 | 12 | 15 | 20 | 11 | 7 | 13 | 13 | 66 | 56 |

*Labour Force Status*

Individuals who were employed were somewhat more likely to be health volunteers than were those who were unemployed or not in the labour force, but those who were not in the labour force contributed more hours. Those who were not in the labour force accounted for 31% of health volunteers, but 43% of volunteer hours, and volunteered an average of 122 hours. Those who were employed accounted for 63% of the population and 65% of health volunteers. They volunteered an average of 69 hours. Those who

were employed part-time were more likely to be volunteers than those who were employed full-time. Part-time employees accounted for 12% of the population and 15% of health volunteers.

*Household Income*

Individuals from higher income households were more likely to be health volunteers than were those from low income households, but contributed proportionally fewer hours. Individuals with household incomes greater than $100,000 made up 12% of the population, but 20% of health volunteers and accounted for only 7% of hours volunteered to health organizations. Those with household incomes of less than $20,000 made up 13% of the population, only 7% of health volunteers, but accounted for 14% of health volunteer hours.

**Changes from 1997 to 2000**

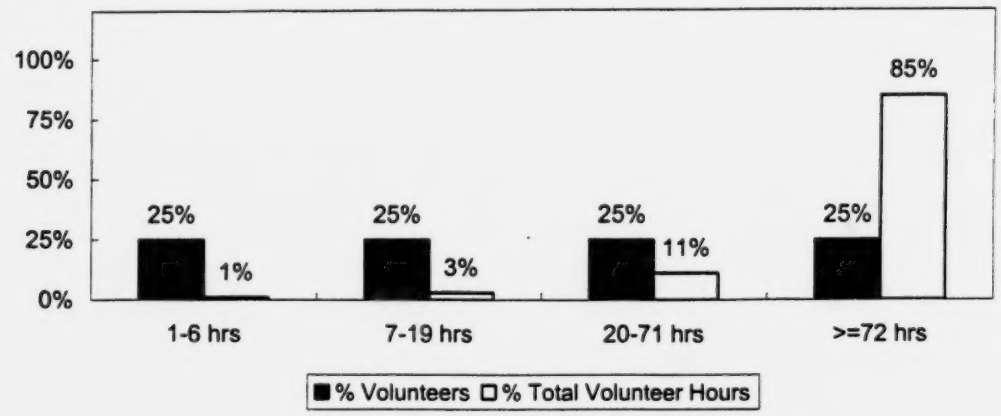
Overall, there were only a few significant increases and decreases in the volunteering patterns across demographic groups between 1997 and 2000. The percentage of health volunteers who were employed (whether full-time or part-time) increased from 62% in 1997 to 65% in 2000. Interestingly, the increase was even greater among those who were employed full-time, where the percentage of health volunteers who were employed jumped from 44% in 1997 to 51% in 2000. The percentage of health volunteers from households with high incomes also increased. Individuals with household incomes greater than $100,000 made up 20% of health volunteers in 2000, up from 15% in 1997. There was also a significant increase in the percentage of health volunteers with a university education, from 19% in 1997 to 24% in 2000. The health volunteer rate declined from 5% in 1997 to 3% in 2000 among those who were 65 years of age or older. Survey data does not provide enough information to determine whether these changes were due to changes in health organization volunteers or to changes in the Canadian population as a whole.

## Who Contributes the Most Volunteer Hours?

A small number of health volunteers took on most of the volunteer work in 2000. The top quarter of the health volunteers – those who volunteered 72 hours or more – accounted for 85% of all hours volunteered for health organizations (Figure 9). The remaining three-quarters of health volunteers accounted for just 15% of the total hours. As Figure A.9 (see Appendix A) illustrates, this is similar to the situation in 1997, when the top quarter of health volunteers[12] contributed 83% of total volunteer hours.

[12] Defined in 1997 as those individuals who donated 60 or more hours to health organizations. This definition is slightly different from the definition used in 2000 because the average number of hours volunteered to health organizations increased from 73 in 1997 to 87 in 2000.

**Figure 9: Concentration of Volunteer Support for Health Organizations, 2000**




## Who are the Top Health Volunteers?

Because the top quarter of health volunteers accounted for such a large percentage of the total number of hours volunteered for health organizations, it is essential to understand how they differ from other health volunteers. Table 14 compares top health volunteers to the other health volunteers. Generally, the top quarter of health volunteers were more likely to be over the age of 55, female, not in the labour force, and to have lower household incomes.

*Age*

Those aged 55 or more were more likely to be top health volunteers than were any other age groups. They accounted for 39% of top health volunteers and only 20% of the remainder of health volunteers. Those aged 35 to 54, in contrast, made up 36% of top volunteers, but 51% of other health volunteers.

*Sex*

Although women made up a much larger percentage of health volunteers, men tended to represent a relatively larger proportion of top volunteers. Men accounted for 38% of top health volunteers and 33% of other health volunteers. Women make up the overwhelming majority of top quarter of health volunteers (62%) as well as other health volunteers (67%).

*Education*

Educational level attained does not appear to have any huge effects, save for the fact that individuals with less than a high school diploma appear to be somewhat more likely to be top volunteers.

*Labour Force Status*

Those not in the labour force were far more likely to be top volunteers (47% of top health volunteers vs. 25% of other health volunteers), while those who were employed, particularly full-time, were less likely to be top volunteers.

*Household Income*

Individuals with household incomes of $60,000 or more were less likely to be top health volunteers, while those with smaller household incomes were more likely to be top volunteers. Those with household incomes greater than $100,000 made up 14% of top health volunteers, but 22% of other health volunteers. Those with household incomes less than $20,000 made up 14% of top health volunteers, but accounted for only 5% of other health volunteers.

**Table 14: Demographic Characteristics of Top and Other Health Volunteers, Voluntary Health Organizations, 2000 and 1997**

| | 2000 | | 1997 | |
|---|---|---|---|---|
| | % Top Volunteers | % Other Health Volunteers | % Top Volunteers | % Other Health Volunteers |
| **Age Group** | | | | |
| 15-24 Years | 13 | 14 | 15 | 13 |
| 25-34 Years | 12 | 14 | 11 | 16 |
| 35-44 Years | 18 | 25 | 17 | 23 |
| 45-54 Years | 18 | 26 | 23 | 24 |
| 55-64 Years | 17 | 13 | 16 | 11 |
| 65 Yrs and Over | 22 | 7 | 18 | 12 |
| **Sex** | | | | |
| Male | 38 | 33 | 30 | 31 |
| Female | 62 | 67 | 70 | 69 |
| **Marital Status** | | | | |
| Married / Common Law | 63 | 70 | 60 | 67 |
| Single, Never Married | 21 | 20 | 25 | 22 |
| Widow / Widower | 11 | 2 | 7 | 5 |
| Separated / Divorced | 5 | 7 | 9 | 5 |
| **Education Level** | | | | |
| < High School | 17 | 13 | 15 | 16 |
| High School | 17 | 16 | 17 | 22 |
| Some Post-Secondary | 11 | 14 | 10 | 10 |
| Post-Secondary Diploma | 31 | 32 | 36 | 34 |
| University Degree | 24 | 25 | 22 | 18 |
| **Labour Force Status** | | | | |
| Employed | 48 | 71 | 51 | 65 |
| *Full-Time* | *35* | *56* | 33 | *47* |
| *Part-Time* | *13* | *15* | *18* | *18* |
| Unemployed | 5 | 3 | 4 | 4 |
| Not in Labour Force | 47 | 25 | 44 | 31 |
| **Household Income** | | | | |
| < $20,000 | 14 | 5 | 20 | 12 |
| $20,000-<$40,000 | 24 | 20 | 22 | 21 |
| $40,000-<$60,000 | 24 | 19 | 25 | 22 |
| $60K-<$100K | 25 | 34 | 20 | 29 |
| >$100,000 | 14 | 22 | 12 | 15 |

# The Role of Religion

Religious affiliation and participation is often associated with higher rates of volunteering. Indeed, in 2000, individuals who claimed a religious affiliation were somewhat more likely to volunteer for health organizations (74% of the population and 77% of health volunteers), while those who attended religious services weekly were significantly more likely to do so (19% of the population and 27% of health volunteers). Those who identified themselves as being very religious were also somewhat more likely to volunteer for health organizations (11% of the population and 14% of health volunteers).

**Table 15: Religion Related Characteristics of Health Volunteers, 1997 and 2000**

| | % Canadian Population | | % Health Volunteers | | Health Volunteer Rate (%) | | % Total Health Hours | | Mean Health Hours | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1997 | 2000 | 1997 | 2000 | 1997 | 2000 | 1997 | 2000 | 1997 | 2000 |
| **Religious Affiliation** | | | | | | | | | | |
| No Affiliation | 25 | 26 | 20 | 23 | 4 | 4 | 17 | 24 | 61 | 90 |
| Affiliation | 75 | 74 | 80 | 77 | 6 | 5 | 83 | 76 | 76 | 86 |
| **Religious Attendance** | | | | | | | | | | |
| Weekly | 20 | 19 | 30 | 27 | 8 | 7 | 37 | 26 | 88 | 83 |
| Not Weekly | 80 | 81 | 70 | 73 | 5 | 4 | 63 | 74 | 66 | 89 |
| **Religiosity** | | | | | | | | | | |
| Very Religious | 12 | 11 | 18 | 14 | 8 | 6 | 16 | 13 | 65 | 78 |
| Not Very Religious | 88 | 89 | 82 | 86 | 5 | 5 | 84 | 87 | 74 | 87 |

Individuals who identified themselves as very religious or those who attended services on a weekly basis were somewhat more likely to be top volunteers (15% of top health volunteers vs. 14% of other health volunteers and 29% of top health volunteers vs. 27% of other health volunteers respectively). However, individuals with a religious affiliation were less likely to be top health volunteers (75% of top health volunteers vs. 78% of other health volunteers).

**Table 16: Religion Related Characteristics of Top and Other Health Volunteers, Voluntary Health Organizations, 2000 and 1997**

| | 2000 | | 1997 | |
|---|---|---|---|---|
| | % Top Volunteers | % Other Health Volunteers | % Top Volunteers | % Other Health Volunteers |
| **Religious Affiliation** | | | | |
| No Affiliation | 25 | 22 | 22 | 20 |
| Affiliation | 75 | 78 | 78 | 80 |
| **Religious Attendance** | | | | |
| Weekly | 29 | 27 | 34 | 29 |
| Not Weekly | 71 | 73 | 66 | 71 |
| **Religiosity** | | | | |
| Very Religious | 15 | 14 | 17 | 18 |
| Not Very Religious | 85 | 86 | 83 | 82 |

## Support of Health Volunteers for Other Causes

Like health donors, health volunteers support causes other than health. In fact, health volunteers give their time to more types of organizations than most other volunteers. They volunteered for an average of 2.2 types of organizations in 2000, which ties them with environmental volunteers, who supported 2.2 organization types (Table 17) and places them second only to law, advocacy and politics volunteers, who volunteer for 2.3 types of organizations. This is similar to the pattern in 1997. Of particular note is the widespread decrease in the average number of organizations supported from 1997 to 2000. The average number of organizations volunteered for increased only among health volunteers (from 2.1 in 1997 to 2.2 in 2000).

**Table 17: Average Number of Organizations Supported by Volunteer Type, 2000 and 1997**

| Organization Type | 2000 | 1997 |
|---|---|---|
| **Health** | **2.2** | **2.1** |
| Law, Advocacy and Politics | 2.3 | 2.3 |
| Environmental | 2.2 | 2.3 |
| Development and Housing | 2.1 | 2.2 |
| Professional Associations and Unions | 2.1 | 2.3 |
| Philanthropic Intermediaries and Voluntarism Promotion | 2.0 | 2.2 |
| Social Services | 2.0 | 2.1 |
| International | 2.0 | 2.3 |
| Religion | 2.0 | 2.1 |
| Arts, Culture and Recreation | 2.0 | 2.1 |
| Education and Research | 2.0 | 2.1 |
| Other | 1.7 | 2.1 |

Unsurprisingly, the rates at which health volunteers volunteer for other organization types vary significantly. Generally speaking, health volunteers are most likely to also volunteer for the same types of organizations that regular volunteers[13] are. Social services; arts, culture and recreation; religion; and education and research organizations are the types of organizations that health volunteers are most likely to support in addition to health organizations. Health volunteers tend to volunteer for some types of organizations more frequently than regular volunteers. Health volunteers are more likely to volunteer for social services (36% of health volunteers volunteer for social services, compared to 27% of regular volunteers), development and housing (8% of health volunteers and 7% of regular volunteers) and philanthropic intermediaries and voluntarism promotion organizations (7% of health volunteers and 3% of regular volunteers[14]). Health volunteers are less likely to also volunteer for education and research (15% of health volunteers and 19% of regular volunteers); arts, culture and recreation organizations (28% of health volunteers and 30% of regular volunteers).

**Table 18: Rate of Volunteering by Organization Type, Health Volunteers and Regular Volunteers, 2000**

| Organization Type | Health Volunteers | Regular Volunteers |
|---|---|---|
| **Health** | **100%** | **17%** |
| Social Services | 36% | 27% |
| Arts, Culture and Recreation | 28% | 30% |
| Religion | 23% | 21% |
| Education and Research | 15% | 19% |
| Development and Housing | 8% | 7% |
| Philanthropic Intermediaries and Voluntarism Promotion | 7% | 3% |
| Law, Advocacy and Politics | 4% | 5% |
| Environmental | 4% | 4% |
| Professional Associations and Unions | 3% | 3% |
| Other | 1% | 2% |
| International | 1% | 1% |

Health volunteers devote the majority of their time (51%) to health organizations (Table 19). Whereas arts, culture and recreation organizations attract 26% of the hours of regular volunteers, they receive only 13% of the total hours volunteered by health volunteers. Social service organizations draw 20% of the hours of regular volunteers, but only 13% of the hours given by health volunteers.

[13] Regular volunteers are defined as individuals who volunteered at least once for any type of organization. Health volunteers are also regular volunteers (i.e. health volunteers are a subset of regular volunteers).
[14] This is particularly of note due to the magnitude of the difference, even though the absolute percentages of volunteers are small.

**Table 19: Allocation of Volunteer Hours, Health Volunteers and Regular Volunteers, 2000**

| Organization Type | Health Volunteers | Regular Volunteers |
|---|---|---|
| **Health** | **51.3%** | **9.2%** |
| Social Services | 12.7% | 20.4% |
| Arts, Culture and Recreation | 12.6% | 25.9% |
| Religion | 8.4% | 16.1% |
| Education and Research | 6.7% | 10.6% |
| Law, Advocacy and Politics | 1.8% | 3.8% |
| Development and Housing | 1.6% | 4.9% |
| Philanthropic Intermediaries and Voluntarism Promotion | 1.2% | 1.2% |
| Professional Associations and Unions | 0.8% | 2.1% |
| Environmental | 0.7% | 2.6% |
| Other | 0.3% | 1.2% |
| International | 0.2% | 0.9% |

## Volunteering for Health Organizations: Motivations and Barriers

Canadians volunteer for a variety of reasons. Of these, personal motivations and connections are the most important for health volunteers. As Table 20 shows, more health volunteers cited a personal belief in the cause that the organization supports (96%) than any other motivation. Health volunteers were more likely than non-health volunteers to report that they volunteered because they were personally affected by the cause they supported (75% vs. 67% of non-health volunteers). They were less likely to say they were motivated by a desire to make use of their skills and experiences (71% vs. 83% of non-health volunteers) or to explore their own strengths (53% vs. 58% of non-health volunteers). Comparatively few health volunteers got involved out of a desire to improve their job opportunities (19%) or because they were required to volunteer by their school or some other institution (9%).With one exception, the motivations of health volunteers remained relatively constant between 1997 and 2000. Whereas 26% of health volunteers cited religious obligations or beliefs as a motivation in 1997, this slipped to 22% in 2000. Interestingly, there were far larger shifts in the motivations of non-health volunteers (for example, 25% of volunteers in 1997 volunteered because their friends volunteered, compared to 31% in 2000).

**Table 20: Motivations for Volunteering, Health Volunteers, 2000 and 1997**

| | 2000 | | 1997 | |
|---|---|---|---|---|
| | Health Volunteers | Non-Health Volunteers | Health Volunteers | Non-Health Volunteers |
| Personal belief in the cause | 96% | 95% | 98% | 96% |
| Personally affected or know someone affected | 75% | 67% | 76% | 65% |
| Want to use skills and experiences | 71% | 83% | 72% | 79% |
| Want to explore own strengths | 53% | 58% | 52% | 55% |
| Because friends volunteer | 25% | 31% | 23% | 25% |
| Fulfill religious obligations or beliefs | 22% | 27% | 26% | 30% |
| Want to improve job opportunities | 19% | 23% | 20% | 22% |
| Required to volunteer | 9% | 7% | --- | --- |

Of all the barriers that prevented health volunteers from volunteering more time, time factors continued to be the most important.[15] This is an increase from 71% in 1997. As Table 21 illustrates, over three-quarters (76%) of health volunteers said they did not volunteer more because they did not have any extra time. Over one-third (34%) said they were unwilling to make a year-round commitment. One quarter (25%) said they gave money instead of time, up from 21% in 1997). This may also reflect time constraints.

Other barriers were far less important to health volunteers. Thirty percent felt that they had already made a sufficient voluntary contribution, and 25% said they gave money instead of time. Health or physical problems deterred almost one in five (18%). Only 7% cited dissatisfaction with previous volunteer experiences.

Some barriers increased in importance since 1997. Health volunteers reported more time stress. In 2000, 76% said they did not have extra time, up from 71% in 1997. An increasing number said they gave money instead of time (25% versus 21% in 1997), which may also reflect time constraints.

[15] Health volunteers were asked if any of these factors were barriers to them volunteering more time.

**Table 21: Barriers to Volunteering More, Health and Non-Health Volunteers, 2000 and 1997**

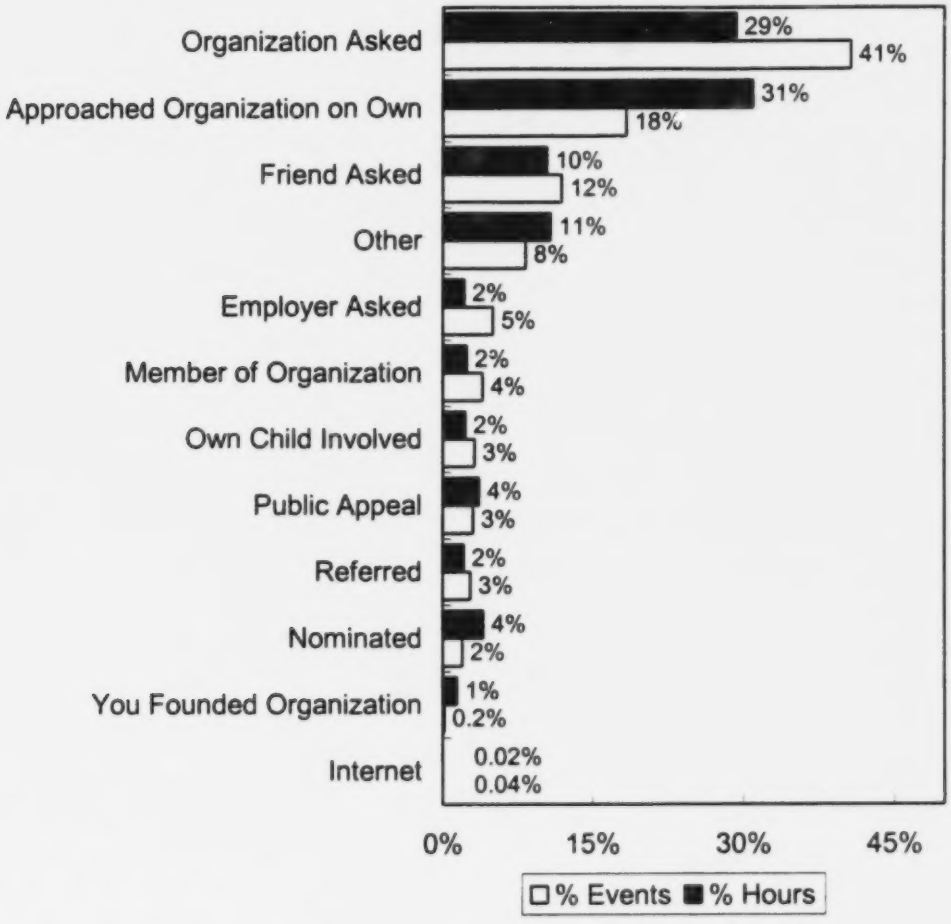
| | 2000 | | 1997 | |
|---|---|---|---|---|
| | Health Volunteers | Non-Health Volunteers | Health Volunteers | Non-Health Volunteers |
| Do not have any extra time | 76% | 75% | 71% | 75% |
| Unwilling to make year-round commitment | 34% | 33% | 35% | 35% |
| Have already made contribution to volunteering | 30% | 29% | 30% | 31% |
| Give money instead of time | 25% | 23% | 21% | 19% |
| No one you know has personally asked you | 19% | 17% | 18% | 18% |
| Have health problems or physically unable | 18% | 15% | 15% | 13% |
| Have no interest | 12% | 17% | 10% | 13% |
| Financial cost of volunteering | 11% | 13% | 11% | 14% |
| Do not know how to become involved | 8% | 10% | 7% | 8% |
| Dissatisfied with previous volunteer experience | 7% | 8% | --- | --- |
| Concerns could be sued/taken to court | 3% | 6% | 3% | 4% |

## How Volunteers Became Involved in Health Organizations

Canadians became health volunteers in a variety of ways. More health volunteers got involved as a result of being asked than in any other way. Almost four in ten began volunteering because they were asked by a voluntary health organization. Indeed, health volunteers were far more likely than non-health volunteers to get involved in this way (41% of health volunteer events vs. 28% of non-health volunteer events). The next most common ways were approaching the organization themselves (18% of volunteer events) and being asked to volunteer for the organization by a friend (12%).

Not all means of volunteer recruitment resulted in the same commitment of hours, however. Health volunteers who started volunteering after approaching the organization themselves were responsible for the largest percentage of volunteer hours (31% of volunteer hours). Being asked by the organization to volunteer accounted for 29% of total volunteer hours and being asked by a friend accounted for 10% of total volunteer hours (Figure 10).

**Figure 10: Percentage of Volunteer Events and Percentage of Total Volunteer Hours by Recruitment Method, 2000**



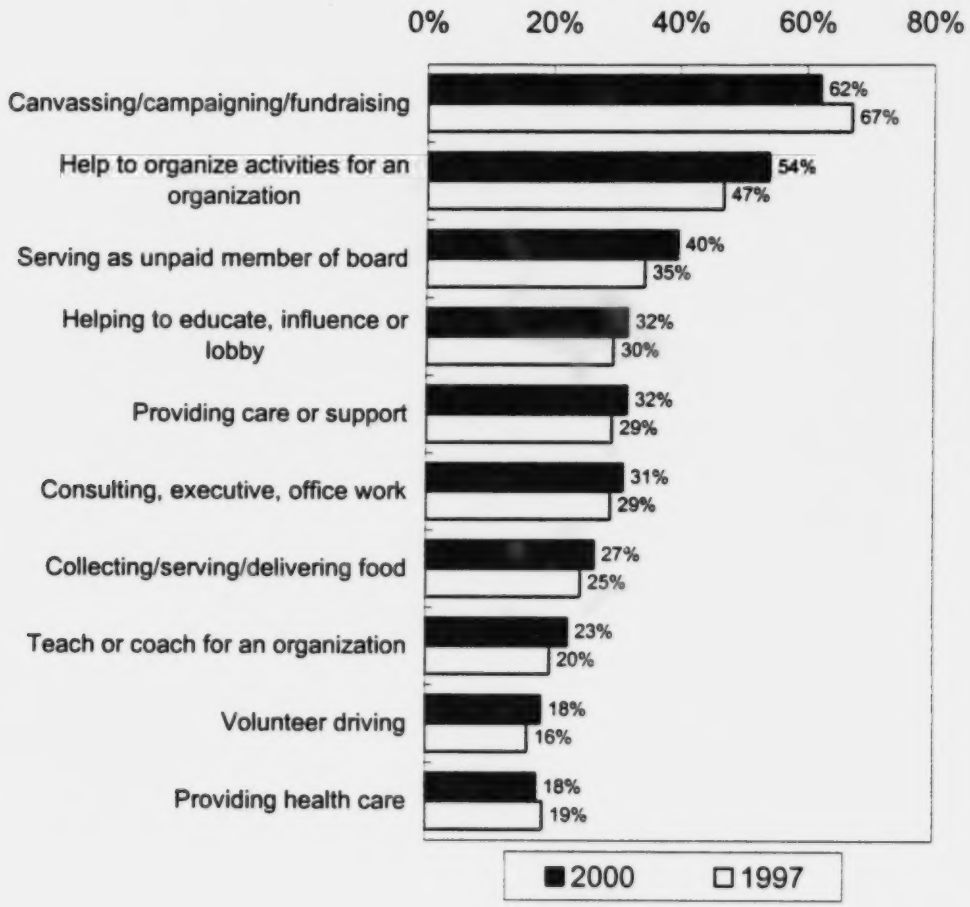

The only significant change in recruitment avenues between 1997 and 2000 was the drop in those who became involved because they were approached by the voluntary organization (47% of volunteer events in 1997 vs. 41% in 2000). Although the percentage of total volunteer hours contributed by these volunteers remained relatively consistent (30% of volunteer hours in 1997 vs. 29% in 2000), it does suggest some change in the type or frequency of appeal being made by health organizations and/or the willingness or ability of volunteers to respond

## What Health Volunteers Do

Health volunteers engage in a wide spectrum of activities in support of voluntary health organizations. They play a particularly strong role in fundraising. As in 1997, the majority (62%) participated in fundraising activities – canvassing, campaigning, or other

fundraising (Figure 11). This is a decline, however, from 67% in 1997. The next most common activity was organizing events, which increased in importance from 47% of volunteers in 1997 to 54% in 2000. Four in ten health volunteers (40%) served as unpaid board members, up from 35% in 1997. Indeed, with the exception of fundraising and providing health care, volunteer participation increased in almost every area of activity.

**Figure 11: Volunteer Activities Undertaken by Health Volunteers, 2000 and 1997**



# Conclusion

The contribution of health donors and volunteers continues to be important to Canada's voluntary health organizations. The good news is that a slightly higher percentage of Canadians made donations to voluntary health organizations in 2000 and contributed over $200 million more than they did in 1997. And while fewer Canadians volunteered for health organizations in 2000, they gave almost 4 million more hours than they did in 1997.

Canadians' support for voluntary health organizations appears to have been motivated by a personal belief in and a personal connection to the work of these organizations. Canadians gave and volunteered because they or someone they knew was personally affected by the areas or issues related to the work of the voluntary health organizations and because they believe that the work of these organizations is important. They were far more likely to cite these motivations than were other donors and volunteers. This personal connection may be an asset that can be used by health organizations to further develop their relationships with current donors and volunteers as well as to increase voluntary support.

While the total amount of donor and volunteer support to health organizations grew between 1997 and 2000, health organizations may nevertheless be concerned about the narrow concentration of that base of support and the apparent impediments to increasing it. The bulk of support for voluntary health organizations – both donations and volunteer hours – came from a relatively small percentage of donors and volunteers. Twenty-five percent of health donors accounted for 75% of total donations in 2000. Similarly, 25% of health volunteers shouldered 85% of the volunteer burden. Clearly, any decline in the numbers of these supporters or in their ability to continue giving could have a significant impact on health organizations.

Health donors appeared to be increasingly dissatisfied with the way in which they are asked for donations. Nearly half (48%) cited this as a barrier to increasing their giving, up from 44% in 1997, suggesting that steps should be taken to cultivate these donors and solicit their support in ways that are more appealing to them. Uncertain economic times also appear to have had an impact. Forty-eight percent of health donors said they did not give more because they preferred to save their money for their own future needs.
Among health volunteers, time is an increasingly scarce commodity. Over three-quarters (76%) said they did not volunteer more because they did not have any time to do so. This is up from 71% in 1997. Over one-third (34%) did not get more involved because they were unwilling to make a year-round commitment. Health organizations may need to restructure their volunteer opportunities to accommodate those who are short on time or who want to make less of a commitment.

As we noted at the beginning of this report, voluntary health organization donors and volunteers play an important role in financing and delivering health programs and services. Fundraising managers and those responsible for volunteer recruitment and management can benefit from a more comprehensive understanding of the various

personal characteristics, economic factors, motivations, barriers and experiences that help to influence decisions about donating and volunteering. Through its analysis of donation and volunteering patterns, this report has contributed to that understanding.

# Appendix A: Tables and Figures, 1997

**Figure A.1. Percentage of Donations and Percentage of Total Donation Value by Organization Type, 1997**

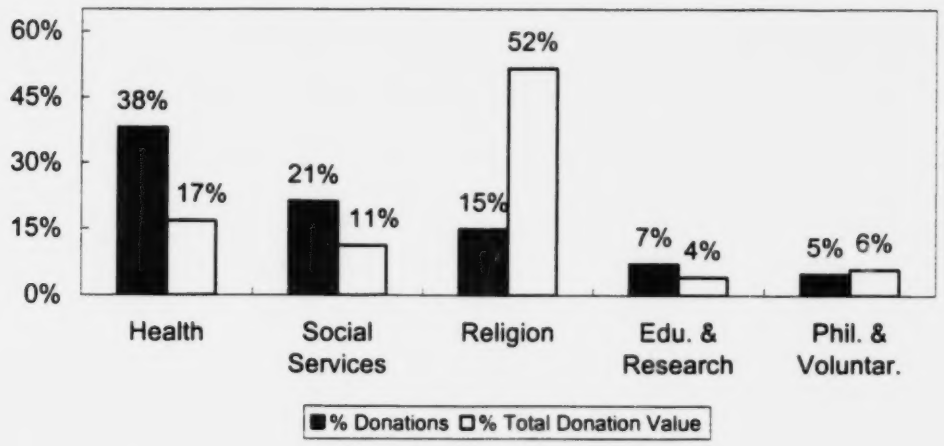



**Figure A.2. Percentage of Canadians Who Donated to Health Organizations by Province, 1997**

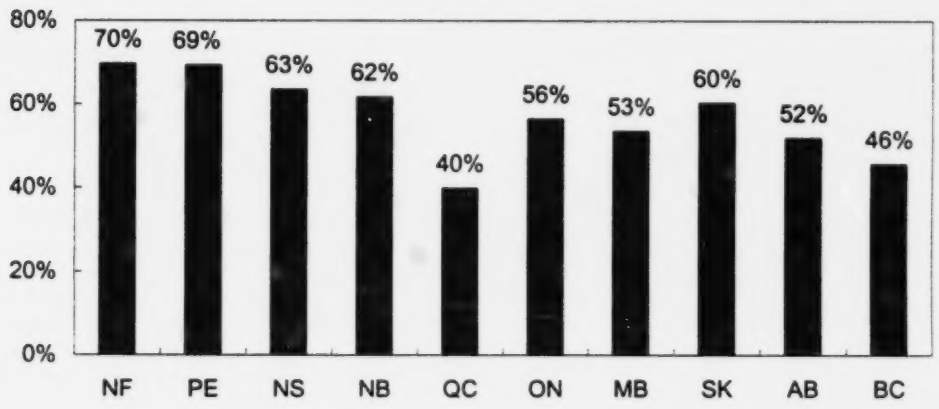


**Figure A.3: Average Annual Donation to Voluntary Health Organizations by Province, 1997**

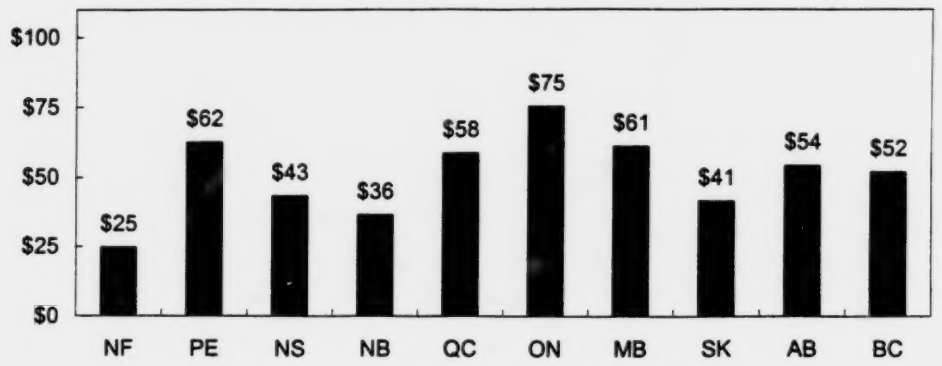



**Figure A.4: Concentration of Monetary Support for Voluntary Health Organizations, 1997**

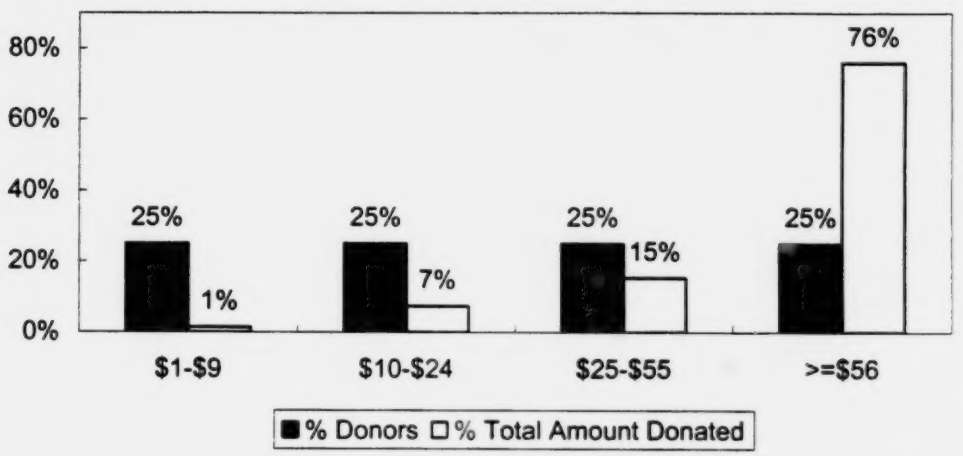


**Figure A.5: Percentage of Donations and Percentage of Total Donation Value by Request Type, 1997**

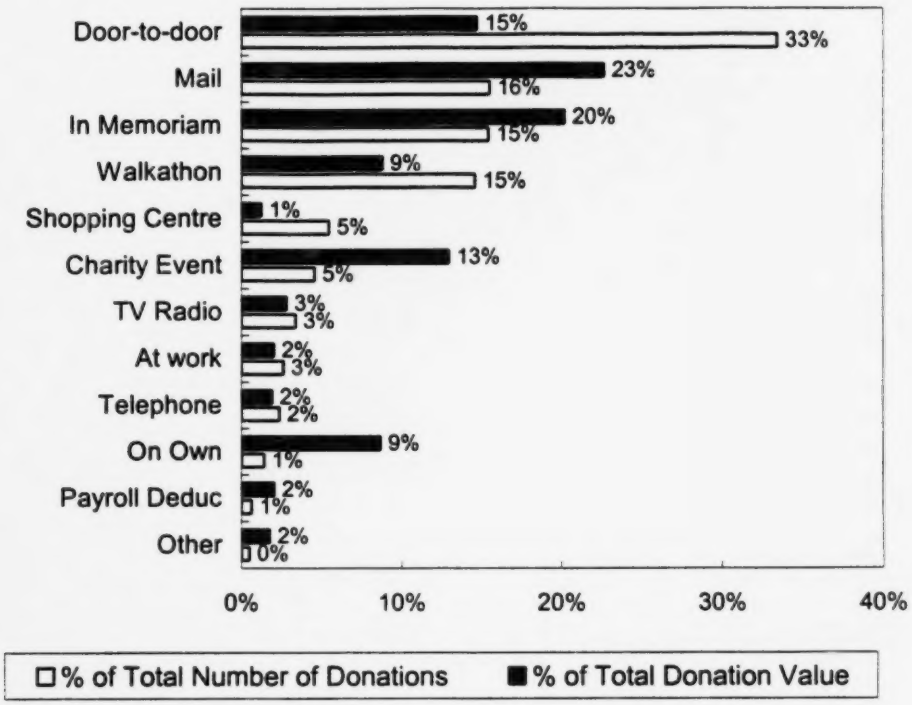


**Figure A.6: Percentage of Volunteer Events and Percentage of Total Volunteer Hours by Organization Type, 1997**

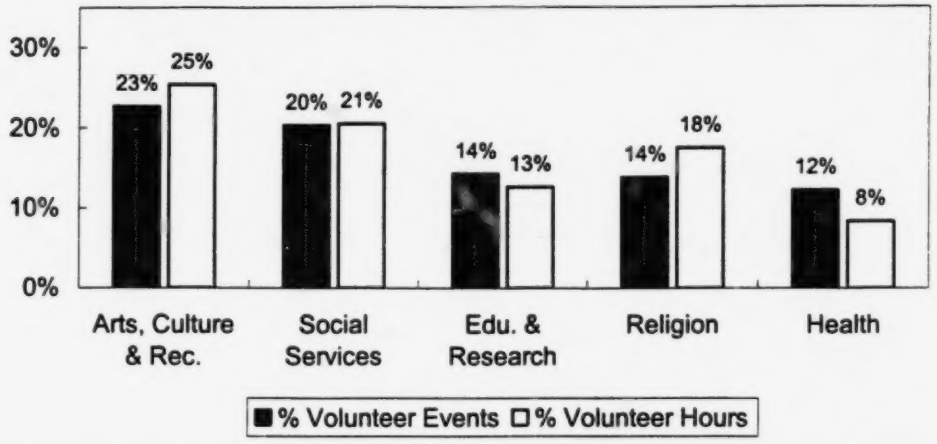



**Figure A.7: Percentage of Canadians who Volunteered for Health Organizations by Province, 1997**

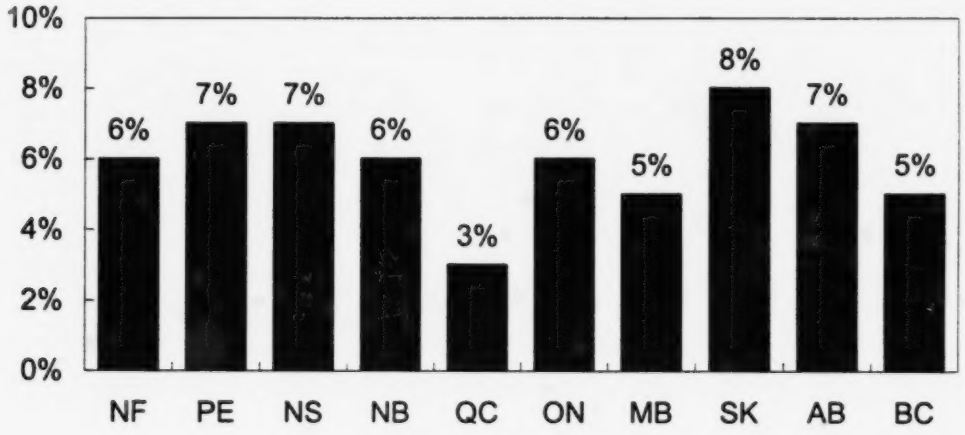


**Figure A.8: Average Number of Hours Volunteered Annually to Health Organizations by Province, 1997**

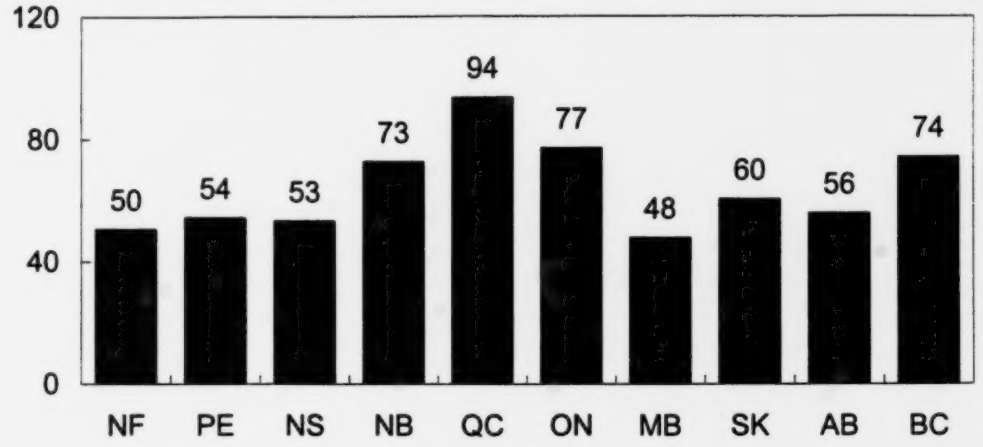


**Figure A.9: Concentration of Volunteer Support for Health Organizations, 1997**

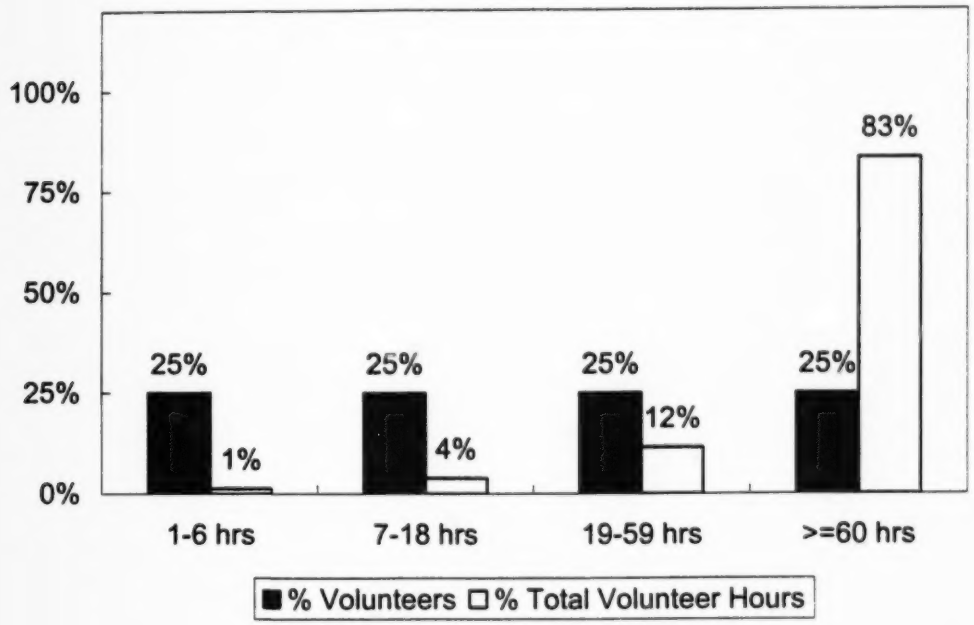


**Figure A.10: Percentage of Volunteer Events and Percentage of Total Volunteer Hours by Recruitment Method, Health Organizations, 1997**

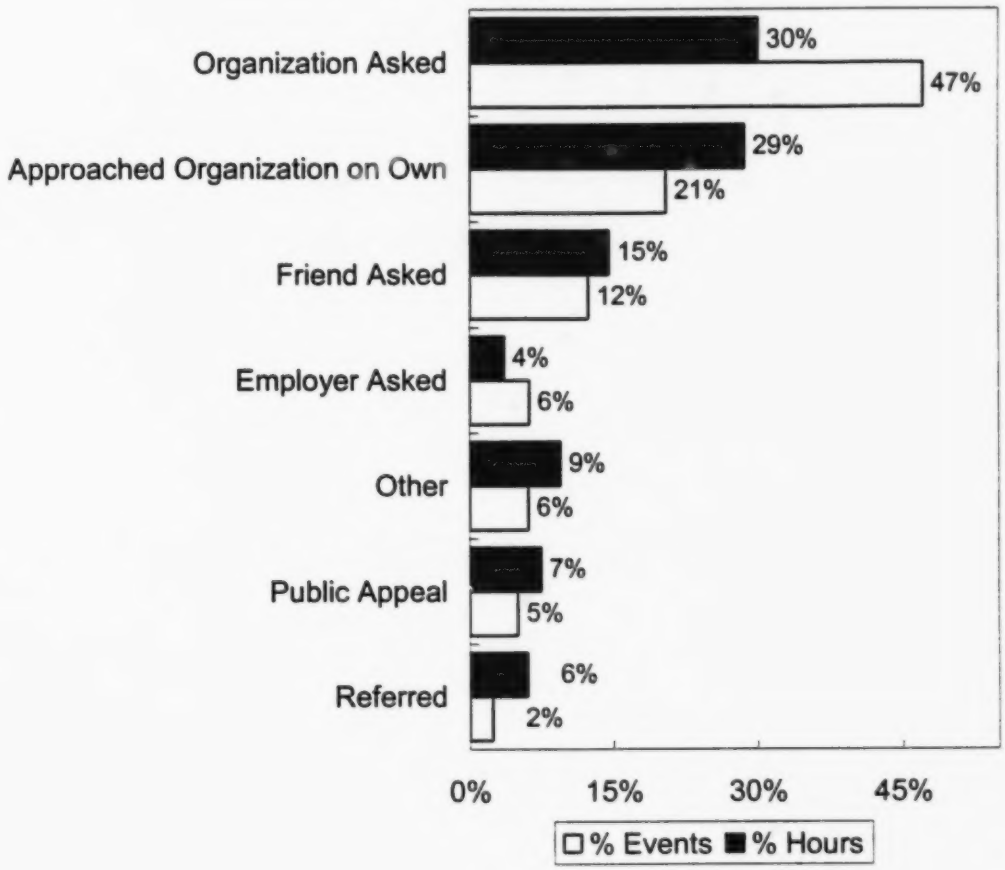


**Table A.1: Donation Rate, Total Amount Donated and Average Donation by Organization Type, 1997**

| | Donation Rate | Total Amount Donated | Average Donation |
|---|---|---|---|
| | (%) | ($'000,000) | ($) |
| **Health** | **51.0%** | **747.6** | **62** |
| Social Services | 40.4% | 501.6 | 52 |
| Religion | 36.0% | 2,289.6 | 267 |
| Education and Research | 18.8% | 183.6 | 41 |
| Philanthropic Intermediaries and Voluntarism Promotion | 14.2% | 262.1 | 78 |
| Arts, Culture and Recreation | 9.7% | 113.6 | 49 |
| Environmental | 5.2% | 69.9 | 57 |
| International | 4.8% | 114.3 | 101 |
| Law, Advocacy and Politics | 3.0% | 45.2 | 64 |
| Other | 1.7% | 19.1 | 46 |
| Development and Housing | 1.6% | 11.5 | 30 |
| Professional Associations and Unions | 0.1% | 1.3 | 50 |
| All Types / Total Donations | 78.0% | 4,435.2 | 239 |

**Table A.7: Support for Organizations, Health Donors and Regular Donors, 1997**

| Organization Type | Health Donors | Regular Donors |
|---|---|---|
| **Health** | **100%** | **51%** |
| Social Services | 56% | 40% |
| Religion | 46% | 36% |
| Education and Research | 25% | 19% |
| Philanthropic Intermediaries and Voluntarism Promotion | 19% | 14% |
| Arts, Culture and Recreation | 13% | 10% |
| Environmental | 8% | 5% |
| International | 6% | 5% |
| Law, Advocacy and Politics | 4% | 3% |
| Development and Housing | 2% | 2% |
| Other | 2% | 2% |
| Professional Associations and Unions | 0% | 0% |

**Table A.8: Allocation of Donation Amounts by Organization Type, Health Donors and Regular Donors, 1997**

| Organization Type | Health Donors | Regular Donors |
|---|---|---|
| **Health** | **21.7%** | **16.9%** |
| Religion | 48.5% | 51.6% |
| Social Services | 10.9% | 11.3% |
| Philanthropic Intermediaries and Voluntarism Promotion | 5.5% | 5.9% |
| Education and Research | 4.0% | 4.1% |
| Arts, Culture and Recreation | 2.5% | 2.6% |
| International | 2.3% | 2.6% |
| Environmental | 1.6% | 1.6% |
| Law, Advocacy and Politics | 1.0% | 1.0% |
| Other | 0.4% | 0.4% |
| Development and Housing | 0.3% | 0.3% |
| Professional Associations and Unions | 0.03% | 0.03% |

**Table A.11: Volunteer Rate, Total Hours Volunteered and Average Hours Volunteered by Type of Organization, 1997**

| Organization Type | Volunteer Rate | Total Hours Volunteered ('000) | Average Hours Volunteered |
|---|---|---|---|
| **Health** | **5.4%** | **92,564** | **73** |
| Arts, Culture and Recreation | 9.6% | 281,418 | 123 |
| Social Services | 9.0% | 227,433 | 106 |
| Education and Research | 6.5% | 140,317 | 91 |
| Religion | 6.5% | 194,231 | 126 |
| Development and Housing | 2.4% | 57,062 | 98 |
| Law, Advocacy and Politics | 1.5% | 33,466 | 94 |
| Environmental | 1.3% | 23,205 | 75 |
| Philanthropic Intermediaries and Voluntarism Promotion | 1.2% | 16,232 | 55 |
| Professional Associations and Unions | 0.6% | 11,022 | 79 |
| International | 0.4% | 6,979 | 69 |
| Other | 0.4% | 7,558 | 88 |

**Table A.18: Rate of Volunteering by Organization Type, Health Volunteers and Regular Volunteers by Organization Type, 1997**

| Organization Type | Health Volunteers | Regular Volunteers |
|---|---|---|
| **Health** | **100.0%** | **17.1%** |
| Social Services | 20.3% | 28.8% |
| Arts, Culture and Recreation | 15.4% | 30.6% |
| Religion | 13.8% | 20.6% |
| Education and Research | 7.9% | 20.7% |
| Development and Housing | 3.5% | 7.8% |
| Philanthropic Intermediaries and Voluntarism Promotion | 3.3% | 4.0% |
| Law, Advocacy and Politics | 2.2% | 4.8% |
| Environmental | 2.2% | 4.1% |
| Professional Associations and Unions | 1.2% | 1.9% |
| International | 1.2% | 1.4% |
| Other | 0.4% | 1.2% |

**Table A.19: Allocation of Volunteer Hours, Health Volunteers and Regular Volunteers, 1997**

| Organization Type | Health Volunteers | Regular Volunteers |
|---|---|---|
| **Health** | **49.0%** | **8.3%** |
| Social Services | 14.2% | 20.5% |
| Religion | 13.8% | 17.5% |
| Arts, Culture and Recreation | 10.3% | 25.4% |
| Education and Research | 3.4% | 12.7% |
| Development and Housing | 1.8% | 5.1% |
| Philanthropic Intermediaries and Voluntarism Promotion | 1.5% | 1.5% |
| Law, Advocacy and Politics | 0.9% | 3.0% |
| Environmental | 0.8% | 2.1% |
| International | 0.7% | 0.6% |
| Professional Associations and Unions | 0.5% | 1.0% |
| Other | 0.3% | 0.7% |

# Charitable Giving to Charitable and Non-Profit Health Organizations: Perspectives Provided from the National Survey of Giving, Volunteering and Participating

**Canadian Centre for Philanthropy / Le centre Canadien de philanthropie**

**And /et**

**Health Canada / Santé Canada**

**Angela Febbraro**
**Michael Hall**

**April 15th, 1999**

Canadian Centre for Philanthropy ™
*Le Centre canadien de philanthropie* ᴹᶜ

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# Table of Contents

**Executive Summary** ..... **130**
**Introduction** ..... **131**
Background ..... 131
The National Survey of Giving, Volunteering and Participating ..... 132
The Definition of Health Used in the NSGVP ..... 132
**The Health Canada Framework for Defining Health, the Voluntary Sector, and the Voluntary Health Sector** ..... **133**
The NSGVP Organizational Classification System ..... 134
Limitations of the NSGVP Organizational Classification System ..... 140
Applicability of the NSGVP Organizational Classification System to the Heath Canada Framework on Health ..... 141
Conclusion ..... 141
**Analysis of Charitable Giving to Voluntary Health Organizations** ..... **142**
Personal and Economic Characteristics of Health Donors ..... 142
A Capacity for Greater Giving? ..... 144
Concentration of Support ..... 145
Provincial Variations ..... 145
Community Size ..... 146
The Role of Religion ..... 147
How Health Donors Make Financial Donations ..... 148
The Reasons Health Donors Make Financial Donations ..... 148
The Role of Tax Credits ..... 149
Links Between Charitable Giving and Other Forms of Support ..... 150
Comparison of Findings on Health Donors and Health Organizations to Overall NSGVP Findings ..... 150
Comparisons Between Health Organizations and Other Types of Organizations ..... 154
Conclusion ..... 155
**Tables** ..... **156**
**References** ..... **162**
**Appendix A Provincial Tables** ..... **163**

# List of Tables

**Table 1** ..... 156
Donor Rate, Average and Median Amount of Donations to Health Organizations, Canadian Population aged 15 and over, 1997

**Table 2** ..... 157
Percentage of Household Income Spent on Financial Donations to Health Organizations by Level of Household Income, Canadian Health Donors aged 15 and over, 1997

**Table 3** ..... 157
Distribution of all Financial Donations to Health Organizations by Size of Annual Donation, Canadian Health Donors aged 15 and over, 1997

**Table 4** ..... 158
Donor Rate, Average and Median Donations to Health Organizations by Province, Canadian Population aged 15 and over, 1997

**Table 5** ..... 158
Donor Rate, Average and Median Donations to Health Organizations by Community Size, Canadian Population aged 15 and over, 1997

**Table 6** ..... 159
Donation Rate to Health Organizations According to Religious Affiliation, Church Attendance and Level of Religious Commitment, Canadian Population aged 15 and over, 1997

**Table 7** ..... 159
Average Donation to Health Organizations Made During the 12-month Reference Period According to Religious Affiliation, Church Attendance and Level of Religious Commitment, Canadian Health Donors aged 15 and over, 1997

**Table 8** ..... 160
Methods of Making Donations as a Percentage of Total Number of Donations and Total Value of Donations, Canadian Health Donors aged 15 and over, 1997

**Table 9** ..... 160
Reasons for Making Donations to Charitable and Nonprofit Organizations, Canadian Health Donors aged 15 and over, 1997

**Table 10** ..... 161
Percentage of Canadian Health Donors who are Claiming a Tax Credit and who would Contribute More if Given a Better Tax Credit, by Amount of Annual Donations to Health Organizations, Canadian Health Donors aged 15 and over, 1997

**Table 11**.....161
Percentage of Canadians aged 15 and over Engaged in Supporting Activities by Amount of Yearly Charitable Contributions to Health Organizations, 1997

# Charitable Giving to Charitable and Non-Profit Health Organizations: Perspectives Provided from the National Survey of Giving, Volunteering and Participating

## Executive Summary

The National Survey of Giving, Volunteering and Participating (NSGVP) is the most comprehensive study of charitable giving and volunteering in Canada to date. Conducted by Statistics Canada in the fall of 1997 and based on interviews with over 18,000 Canadians, it provides important information about the financial support that Canadians give to a variety of voluntary organizations, including voluntary health organizations. Such information is of critical importance to the voluntary health sector as well as to Health Canada, particularly within an environment of tight fiscal constraints.

Health Canada's Joint Working Group on the Voluntary Sector (1999) assumes a definition of health that takes into account the physical, mental, and emotional health of all Canadians as well as a wide range of determinants of health (e.g., physical, genetic, social, economic, cultural). Further, the Joint Working Group on the Voluntary Sector (1999) defines voluntary health organizations as those organizations that are primarily engaged in health activities or that have the health of Canadians as their primary focus. The system of classification of health organizations used in the National Survey of Giving, Volunteering and Participating is derived from the International Classification of Nonprofit Organizations (ICNPO) developed by Salamon and Anheier (1997). This classification system allows for the assessment of public support for organizations that are engaged in activities directly related to health (e.g., hospitals, disease-related fundraising organizations, clinics).

This report has two main objectives. First, it assesses the implications of the current NSGVP classification of health organizations for interpreting survey findings given the definition of health used by Health Canada and elaborated by the Joint Working Group on the Voluntary Sector (1999). Second, it provides an analysis of the NSGVP data on giving to voluntary health organizations and illustrates how the present classification system can be employed to derive information about charitable giving to health organizations. As will be shown, and despite some limitations, the current classification of organizations employed in the NSGVP allows for insight into the extent and nature of public support for organizations that are perceived to be working directly on health issues, consistent with the Health Canada framework.

Findings discussed in this report suggest that differences in charitable support to health organizations exist according to personal and economic characteristics, provincial and community size variations, and religious factors. For example, charitable giving tends to increase with age, education, and income. Religion also appears to play a role in enhancing the likelihood and amount of charitable giving to health organizations.

Findings also suggest a concentration of support among large donors, and the potential for increasing charitable support using improved tax incentives. In addition, findings suggest the particular effectiveness of door-to-door canvassers in generating charitable giving among health donors. Motivations for charitable giving among health donors include compassion towards people in need and the desire to help a cause in which they personally believe. Finally, findings suggest important linkages among various forms of charitable support, such as charitable giving, volunteering and participating, on the part of health donors. In general, the findings are highly consistent with those discussed in Caring Canadians, Involved Canadians: Highlights from the 1997 National Survey of Giving, Volunteering and Participating.

Information about the charitable giving patterns of the individual Canadians who donate to non-profit and charitable health organizations is vital to the continued growth and sustainability of the voluntary health sector. The findings presented may be used to ensure that voluntary health organizations are able to offer a wide range of services that promote the health and well-being of individual Canadians and communities across Canada.

## Introduction

### Background

Many Canadians provide vital financial support in the form of charitable donations and other assistance to charitable and non-profit organizations in the voluntary sector. This support is no less essential to charitable and non-profit organizations in the voluntary health sector. The financial support that voluntary health organizations receive from individual Canadians represents 16% of their total revenues (Hall & Macpherson, 1997). Without this financial support, voluntary health organizations could not offer as wide a range of services as they currently do, including services such as visiting the infirm, public awareness and education, research into improved care and treatment, family support groups, and other services critical to the health and well-being of Canadians.

Health Canada recognizes the significant contribution of the voluntary health sector in terms of promoting health, public education, the delivery of goods and services and supporting research initiatives. Given the recent restructuring of funding to the Canadian health system, demands for the programs and services of the voluntary health sector have grown and the importance of charitable giving has increased. However, little is known about the capacity of this sector to provide the goods and services required to support the health care system and to assist in maintaining and promoting the health of Canadians. A major purpose of this report is to provide reliable information to the voluntary health sector on those Canadians who contribute financially to health charities in Canada and on their patterns of donating.

The National Survey of Giving, Volunteering and Participating provides vital information on this important source of revenues and also provides insight into the proportion of Canadians that supports charitable and voluntary organizations, including voluntary health organizations. In providing a detailed sketch of those individuals who contribute financially to health charities, such knowledge will strengthen the voluntary health sector's capacity to promote its long-term financial sustainability.

**The National Survey of Giving, Volunteering and Participating**

The National Survey of Giving, Volunteering and Participating (NSGVP) is the most comprehensive study to date of charitable giving and volunteering in Canada. Representing a partnership of seven organizations (the Canadian Centre for Philanthropy, Canadian Heritage, Health Canada, Human Resources Development Canada, the Kahanoff Foundation's Non-Profit Sector Research Initiative, Statistics Canada, and Volunteer Canada), and based on interviews with 18,301 Canadians, the NSGVP provides important perspectives on the financial support that Canadians give to voluntary health organizations.[1] Conducted by Statistics Canada in the fall of 1997 as a supplement to the Labour Force Survey, the NSGVP shows, for example, that 51% of Canadians made at least one financial donation to health organizations in the 12 months prior to the survey (i.e., between November 1, 1996 and October 31, 1997), and that the average size of their donation was $62. This support amounted to a total contribution of $748 million. Such financial support is becoming essential to voluntary organizations as they are being asked to play an increasingly important role in health care within an environment of tight financial constraints.

**The Definition of Health Used in the NSGVP**

Health Canada, the NSGVP partner most specifically concerned with health, defines health from a relatively broad perspective. According to this understanding of health, which is elaborated in a report by the Joint Working Group (JWG) on the Voluntary Sector, health is concerned with the quality of life of all Canadians. It encompasses social, mental, emotional, and physical health, and is influenced by a wide range of biological, social, economic, and cultural factors. Further, according to this framework, health is concerned with health promotion, the prevention of illness, and health protection, as well as the treatment of illness. In accordance with this broad understanding of health, Health Canada includes a broad spectrum of organizations in the voluntary health sector. Such organizations may include those involved in wellness/health promotion, primary care, acute care, or chronic care. Although these organizations cover a broad spectrum of activities, they have in common their primary focus of activity: the health of Canadians.

Reflecting this definition of health, and this understanding of the voluntary health sector, the NSGVP classification of health organizations, which is based on the International Classification of Nonprofit Organizations (Salamon & Anheier, 1997), is also based on a

[1] The sample size of 18,301 reflects a 78.4% response rate.

relatively broad conception of health. However, it too defines health organizations as those organizations that are primarily or directly involved in health activities. These organizations may include hospitals, nursing homes, mental health organizations, and public health and wellness education organizations.

This report has two main objectives. First, it assesses the implications of the current NSGVP classification of health organizations for interpreting survey findings in light of the definition of health used by Health Canada. Second, it provides an analysis of the NSGVP data on giving to voluntary health organizations and illustrates how the present classification system can be employed to derive information about charitable giving to health organizations. Thus, it provides some insight into the extent and nature of public support for organizations that are working directly on health issues.

This report begins by reviewing in greater detail how Health Canada defines health, the voluntary sector, and the voluntary health sector. The report then reviews the organizational classification system employed in the NSGVP and assesses its applicability to the definition of health as viewed by Health Canada. Next, the utility of the NSGVP and its present classification system is illustrated through a number of tables that show the extent and variation in charitable giving to health organizations as defined in the NSGVP.

## The Health Canada Framework for Defining Health, the Voluntary Sector, and the Voluntary Health Sector

Health Canada defines health in a relatively broad sense (Joint Working Group on the Voluntary Sector, 1999). According to this relatively broad understanding of health, health is concerned with the quality of life of the general population, of sub-populations and individuals. Health is viewed as holistic, addressing the overall health of individuals, including social, mental, emotional and physical health. Health is seen as related to the capacity of individuals to influence their own health, the health of others and the health of their communities. Health is considered to be influenced by a broad range of factors and the interaction of these factors, including an individual's biological and genetic endowment, personal health practices and coping skills, social and physical environments, income and social status, employment and working conditions, education, social support networks, early childhood development, gender, culture, and health services. Finally, health is about health promotion, illness prevention, health protection, and quality health care (Joint Working Group on the Voluntary Sector, 1999).

According to the Joint Working Group on the Voluntary Sector (1999), the voluntary sector consists of individuals and organizations whose activities are carried out primarily, but not necessarily exclusively, by volunteers. It has as its essential attribute the willingness of people to donate their time, knowledge, skills, and resources to assist others, and is involved in activities designed to help individuals, families, groups, and communities. Such activities include direct service, information exchange, public

awareness, education, support, fundraising, advocacy, research, public dialogue, and policy development (Joint Working Group on the Voluntary Sector, 1999).

Voluntary organizations, according to the Joint Working Group (JWG) on the Voluntary Sector (1999), include those organizations that help to organize voluntary action and volunteers in order to promote a shared public objective or interest; that provide services, supports and resources; and that engage in dialogue and action. Further, according to the JWG framework, voluntary organizations do not seek profit as an end in itself, and are accountable to constituencies or members through democratic governing structures and/or legal frameworks. Voluntary organizations may encompass national, provincial, territorial, regional, local, grassroots and citizens' organizations, and they may have a financial relationship for which they are accountable with governments, foundations, the private sector, or private citizens, but they are considered autonomous and independent organizations (Joint Working Group on the Voluntary Sector, 1999).

According to the Health Canada framework, the voluntary health sector includes a broad spectrum of organizations in the areas of wellness/health promotion (e.g., community sites such as schools and seniors centres), primary care (e.g., community clinics, doctors offices, and research institutes), acute care (e.g., emergency rooms, hospitals, outpatient care, and rehabilitation services), and chronic care (e.g., homecare, institutional long-term care). As such, the voluntary health sector is an integrator of the health care system for Canadians.

The Joint Working Group on the Voluntary Sector (1999) also outlines a definition of National Voluntary Organizations Working in Health (NVOWH). Such organizations are defined as having the health of the people of Canada as their primary focus. They are considered volunteer in nature and structure, with volunteer participation in governance and/or program and service delivery. Further, they provide a national perspective and undertake activities that are primarily national in scope. Thus, professional associations, which primarily serve and represent their members, are excluded from this framework (Joint Working Group on the Voluntary Sector, 1999).

National voluntary organizations working in health differ in size, scope, origins, and focus. However, they share a large capacity to mobilize volunteers and they contribute millions of volunteer hours annually to benefit the health of Canadians (Joint Working Group on the Voluntary Sector, 1999). Collectively, NVOWH contribute to health by identifying a broad range of emerging issues, including: aboriginal people, adolescents, children, consumers, disabilities, the environment, fitness and active living, families, health protection, human rights, illness and disease, international health, multiculturalism, older persons, research and policy, safety and injury prevention, social development, and women (Joint Working Group on the Voluntary Sector, 1999).

**The NSGVP Organizational Classification System**

The NSGVP classification system is derived from the International Classification of Nonprofit Organizations (ICNPO) developed by Salamon and Anheier (1997) for the

Johns Hopkins Comparative Nonprofit Sector Project. A major advantage of the ICNPO system is that it is used widely by different countries and thus allows for international comparisons. The Johns Hopkins Comparative Nonprofit Sector project presently involves an examination of the nonprofit sectors of 22 countries2 (Salamon, Anheier, & Associates, 1998). The ICNPO distinguishes organizations within the voluntary sector on the basis of their organizational activity. More specifically, organizations are sorted according to the primary type of goods or services each one provides (e.g., health, social services, environment). The ICNPO and the NSGVP divides the voluntary sector into 12 major activity groups (including a catch-all "Not Elsewhere Classified" category), which are further divided into 24 subgroups. The major groups and subgroups are:

1. *Culture and Recreation:* includes organizations and activities in general and specialized fields of culture and recreation. Three sub-groups of organizations are included in this group: (1) culture and arts (i.e., media and communications; visual arts, architecture, ceramic art; performing art; historical, literary and humanistic societies; museums; and zoos and aquariums); (2) sports; and (3) other recreation and social clubs (i.e., service clubs and recreation and social clubs).

2. *Education and Research:* includes organizations and activities administering, providing, promoting, conducting, supporting and servicing education and research. Four sub-groups are contained in this group: (1) primary and secondary education organizations; (2) higher education organizations; (3) organizations involved in other education (i.e., adult/continuing education and vocational/technical schools); and (4) organizations involved in research (i.e., medical research, science and technology, and social sciences).

3. *Health:* includes organizations that engage in health-related activities, providing health care, both general and specialized services, administration of health care services, and health support services. Four sub-groups are included in this category: (1) hospitals and rehabilitation; (2) nursing homes; (3) mental health and crisis intervention; and (4) other health services (i.e., public health and wellness education, out-patient health treatment, rehabilitative medical services, and emergency medical services).

4. *Social Services:* includes organizations and institutions providing human and social services to a community or target population. Three sub- groups are contained in this category: (1) social services (including organizations providing services for children, youth, families, the handicapped and the elderly, and self-help and other personal social services; (2) emergency and relief; and (3) income support and maintenance.

[2] The 22 countries are: Argentina, Australia, Austria, Belgium, Brazil, Colombia, Czech Republic, Finland, France, Germany, Hungary, Ireland, Israel, Italy, Japan, Mexico, The Netherlands, Norway, Peru, Poland, Romania, Russia, Slovakia, South Africa, Spain, United Kingdom, United States, and Venezuela.

5. *Environment:* includes organizations promoting and providing services in environmental conservation, pollution control and prevention, environmental education and health, and animal protection. Two sub-groups are included in this category: environment and animal protection.

6. *Development and Housing:* includes organizations promoting programs and providing services to help improve communities and promote the economic and social well-being of society. Three sub-groups are included in this category: (1) economic, social and community development (including community and neighbourhood organizations); (2) housing; and (3) employment and training.

7. *Law, Advocacy and Politics:* includes organizations and groups that work to protect and promote civil and other rights, advocate the social and political interests of general or special constituencies, offer legal services and that promote public safety. Three sub-groups are contained in this category: (1) civic and advocacy organizations; (2) law and legal services; and (3) political organizations.

8. *Philanthropic Intermediaries and Voluntarism:* includes philanthropic organizations and organizations promoting charity and charitable activities including grant-making foundations, voluntarism promotion and support, and fundraising organizations.

9. *International:* includes organizations promoting cultural understanding between peoples of various countries and historical backgrounds and also those providing relief during emergencies and promoting development and welfare abroad.

10. *Religion:* organizations promoting religious beliefs and administering religious services and rituals; includes churches, mosques, synagogues, temples, shrines, seminaries, monasteries and similar religious institutions, in addition to related organizations and auxiliaries of such organizations.

11. *Business and Professional Associations, Unions:* includes organizations promoting, regulating and safeguarding business, professional and labour interests.

12. *Groups not elsewhere classified.*

It is important to note that each organization was assigned a single code reflecting a single purpose and there are no multi-purpose codes in this classification system (e.g., an organization like the Salvation Army could not be coded as being involved in religion, social services and health). Organizations who provide direct health services as a secondary activity (e.g., a shelter for the homeless that provides some limited health services) cannot be identified in the survey. It may be possible to revisit the coding of the NSGVP to derive multiple codes, but this is not likely to provide sufficient additional information to be worth the effort. Because respondents were not asked to provide

multiple purposes about an organization they are likely to have responded by providing the main single purpose of an organization.

Statistics Canada has indicated to us that the Canadian Cancer Society, the Heart and Stroke Foundation and other such organizations were coded to the Health category and not Education and Research category because these organizations do more than just research (i.e., they engage in health promotion, health education, etc.) and it was thought that they were more appropriately classified under health. The table below details the coding structure employed by Statistics Canada and used in the NSGVP.

| | | |
|---|---|---|
| **Culture and Recreation** | | |
| Public Television | 1110 | media and communications |
| Minor Sports | 1210 | sports clubs |
| Kinsmen Club | 1310 | service clubs |
| Knights of Columbus | 1310 | service clubs |
| Lions Club | 1310 | service clubs |
| Masonic Order/Lodge | 1310 | service clubs |
| Optimist Club | 1310 | service clubs |
| Rotary Club | 1310 | service clubs |
| Royal Canadian Legion | 1310 | service clubs |
| Shriners | 1310 | service clubs |
| **Education and Research** | | |
| Elementary/High Schools | 2100 | elementary, primary and secondary education |
| Elementary/High Schools – Extra-Curricular Activities | 2100 | elementary, primary and secondary education |
| Parent Teacher Association | 2110 | elementary, primary and secondary education |
| School/School Board | 2110 | elementary, primary and secondary education |
| Student Council | 2110 | elementary, primary and secondary education |
| Universities/Colleges | 2210 | higher education |
| **Health** | | |
| Hospital | 3110 | hospitals |
| AIDS | 3400 | other health services |
| Arthritis Society | 3400 | other health services |
| Canadian National Institute for the Blind | 3400 | other health services |
| Cancer Society | 3400 | other health services |
| Cerebral Palsy | 3400 | other health services |
| Cystic Fibrosis | 3400 | other health services |
| Diabetic Association | 3400 | other health services |
| Heart and Stroke Foundation | 3400 | other health services |
| Kidney Society | 3400 | other health services |
| Leprosy Relief | 3400 | other health services |
| Liver Foundation | 3400 | other health services |
| Lung Association | 3400 | other health services |
| Maison Michel Sarrazin | 3400 | other health services |
| Multiple Sclerosis | 3400 | other health services |
| Muscular Dystrophy | 3400 | other health services |
| Leucan | 3440 | emergency medical services |
| Maison De Lauberivière | 3440 | emergency medical services |
| St. John Ambulance | 3440 | emergency medical services |

| | | |
|---|---|---|
| **Social Services** | | |
| Salvation Army | 4000 | social services |
| Care Canada | 4100 | social services |
| Christian Children's Fund | 4100 | social services |
| Covenant House | 4100 | social services |
| Foster Parents Plan | 4100 | child welfare |
| Children's Wish Foundation | 4110 | social services |
| Big Brothers | 4120 | youth services and youth welfare |
| Boy Scouts/Girl Guides | 4120 | youth services and youth welfare |
| YMCA/YWCA | 4120 | youth services and youth welfare |
| Easter Seals | 4140 | services for the handicapped |
| War Amputees | 4140 | services for the handicapped |
| Alcoholics Anonymous | 4160 | self help and other personal social services |
| Red River Fund | 4210 | disaster/emergency prevention and control |
| Volunteer Firefighters | 4210 | disaster/emergency prevention and control |
| Canadian Feed the Children | 4310 | material assistance |
| Meals on Wheels | 4310 | material assistance |
| St. Vincent de Paul | 4310 | material assistance |
| Accueil Bonneau Inc. | 4320 | Income support and maintenance |
| **Environment** | | |
| Nature Conservancy of Canada | 5120 | natural resources conservation |
| Guignlee | 5210 | animal protection and welfare |
| Humane Society | 5210 | animal protection and welfare |
| Ducks Unlimited | 5220 | wildlife preservation and protection |
| World Wildlife Fund | 5220 | wildlife preservation and protection |
| **Development and Housing** | | |
| Chamber of Commerce | 6120 | economic, social and community development |
| **Law, Advocacy and Politics** | | |
| Jewish Federation | 7130 | civic and advocacy organizations |
| Block Parents | 7220 | law and legal services |
| Neighbourhood Watch | 7220 | community and neighbourhood organizations |
| **Philanthropic Intermediaries & Voluntarism** | | |
| United Way | 8100 | fund raising organization |
| United Jewish Appeal | 8130 | philanthropic intermediaries and voluntarism promotion |
| **International** | | |
| Oxfam Canada | 9120 | international activities |
| World Vision | 9120 | international activities |
| Red Cross Society | 9130 | international disaster and relief |
| UNICEF | 9130 | international disaster and relief |
| Amnesty International | 9140 | international human rights |

| Religion | | |
|---|---|---|
| Church/Synagogue/Mosque | 10110 | congregations |
| Woman's League Associated with a Church/ Synagogue/Mosque | 10120 | associations of congregations |

**Limitations of the NSGVP Organizational Classification System**

There are two fundamental limitations of the NSGVP when one considers its suitability for understanding charitable giving to voluntary health organizations. One limitation concerns the way in which the NSGVP collected information about the organizations to which Canadians donated money. The other limitation lies in the way this organizational data has been classified.

NSGVP data on voluntary organizations are limited, in part, by the way in which survey respondents were asked to provide information about the organizations to which they made their donations. The NSGVP was designed to collect information about an organization's primary area of activity (e.g., health, social services, recreation) and not about the other activities in which the organization may be involved. Many organizations may engage in activities which do not focus primarily on health, but which may have a secondary impact on health. For example, the primary focus of a job training program is likely to be placed on securing employment for participants which could, in turn, have a longer term impact on the participant's health. However, within the NSGVP, such a program or organization would not be classified as a health organization.

NSGVP organizational data is limited to information about the name of the organization and, in some cases, responses to the question "What does this organization do?" Survey respondents were only asked for information about what an organization did if they provided the name of an organization that was relatively uncommon. The NSGVP was pre-coded with a "pick-list" of the names of the top 32 fundraising organizations in Canada (or the top 28 fundraising organizations in Quebec). If respondents provided the name of a pre-coded organization they were not asked what the organization did, because this information was already known. When respondents were asked to provide information about what an organization did, Statistics Canada interviewers were instructed to collect detailed information on the area in which the organization provides services (e.g., if someone made a donation to "The Ladies Auxiliary of St. Patrick's Home" and indicated that it "raises funds and organizes social events to assist in providing care and support for the elderly," interviewers were instructed to capture as much of the information as possible and not to simply indicate that the organization "raised funds and organized social events").

Two types of information about voluntary organizations therefore formed the basis for the classification of organizations. If the organization was a pre-identified major fundraiser, classification was based on the common understanding of what an

organization's major area of activity was. If the organization was relatively uncommon, its classification was based on information collected from respondents about what the organization did. It is important to note that respondents provided information about the major activities of an organization (e.g., environmental advocacy, provision of recreation opportunities, income support) and not the health outcomes of such activities. Thus, information about the health-related activities of some organizations may not have been captured by the NSGVP.

**Applicability of the NSGVP Organizational Classification System to the Health Canada Framework on Health**

The International Classification of Nonprofit Organizations (ICNPO), on which the NSGVP organizational classification system is based, includes as health organizations hospitals and rehabilitative facilities, nursing homes, mental health and crisis intervention centres and other health services (including public health and wellness education, outpatient treatment, rehabilitative medical services and emergency medical services). As such the NSGVP is well suited to providing an understanding of the extent to which the public provides support to organizations that are primarily engaged in activities that are directly related to health (e.g., hospitals, disease-related fundraising organizations, clinics). In this respect, the NSGVP is consistent with the framework on health as put forth by Health Canada's Joint Working Group on the Voluntary Sector (1999). Although the Joint Working Group on the Voluntary Sector defines health as being influenced by a broad range of factors (e.g., social, physical, economic, cultural), the primary focus of voluntary health organizations is on the direct health of individuals, rather than on indirect determinants of health, such employment. Once again, this focus is consistent with the characteristics of health organizations as defined in the ICNPO and as employed in the NSGVP. Further, like the Health Canada framework, the ICNPO also assumes that the voluntary sector is involved in activities designed to help others, such as direct service, information exchange, public education, fundraising, and advocacy.[3]

**Conclusion**

Despite some of the limitations noted above, the NSGVP can provide important insights about the financial support that Canadians provide to health care via voluntary health organizations. It can be used, among other things, to show the extent of such support, the way in which such support varies according to key demographic characteristics of the population, as well as some understanding about the reasons for and the barriers to charitable giving.

[3] Despite these similarities, there are some differences between the approach employed in the NSGVP and the Health Canada framework. For example, the ICNPO (and thus the NSGVP) does not assume that the activities of voluntary sector organizations are carried out primarily by volunteers.

## Analysis of Charitable Giving to Voluntary Health Organizations

As discussed in *Caring Canadians, Involved Canadians: Highlights from the 1997 National Survey of Giving, Volunteering, and Participating* (Hall, Knighton, Reed, Bussière, McRae, & Bowen, 1998), 18.6 million Canadians aged 15 and over (78% of the population) made direct financial contributions to charitable and non-profit organizations. This represents a total contribution of $4.44 billion. On average, donors who made financial contributions gave $239 in the 12-month period covered by the survey.

In comparison, 12.1 million Canadians (or 51% of the population) donated to charitable and nonprofit health organizations. Canadians who donated to health organizations are defined as *health donors* in this report. As well as contributing financially to health organizations, Canadian health donors may have also contributed to a variety of other non-health organizations. Thus, in this report, Canadian health donors include those donors who gave to health organizations *only* as well as those donors who gave to health organizations *and* other types of organizations.[4] On average, Canadian health donors contributed $62 to health organizations during the 12-month period covered by the study, representing a total contribution of $748 million.

In the following sections, the utility of the NSGVP and its present classification system is illustrated through a series of tables that demonstrate the extent and variation in charitable giving to nonprofit and charitable health organizations (see Tables 1-11). Topics include the personal and economic characteristics of health donors; the concentration of charitable support; provincial and community size variations in charitable giving; the role of religion; methods of giving; reasons for giving; the role of tax credits; and linkages between charitable giving to health organizations and other forms of support. Comparisons to the overall data on charitable giving as presented in *Caring Canadians* (Hall et al., 1998) are also offered. Finally, comparisons between health organizations and other types of organizations are briefly outlined.

### Personal and Economic Characteristics of Health Donors

The incidence of charitable giving and the amount given to health organizations varies across demographic groups within the Canadian population. The incidence of charitable giving to health organizations, or the *health donor rate*, is defined as the proportion of individuals in the Canadian population aged 15 and over who made financial donations to health organizations during the 12-month period covered by the survey, or the reference year. The amount of giving to health organizations is measured by the *mean* (or average) amount of donations and by the *median* amount of donations made by health donors to health organizations during the reference year.[5] It should be noted that acts of charitable

[4] The number of Canadian donors who gave only to health organizations is 1.7 million (or 7% of the population aged 15 and over).

[5] The median is the statistical "halfway point" of a distribution of values and provides a measure of how much the "typical" donor gives. In this case, half of all health donors gave less than the median value and half of all health donors gave more than the median value. Unlike the mean, the median value is not influenced by extreme values or outliers.

giving, whether to health organizations or to any other type of organization, result from a variety of factors, including financial capacity to give, values and attitudes toward giving, and opportunities to give. Thus, differences in donor rates or amounts of charitable giving may not reflect variations in generosity or any other internal altruistic characteristic per se, but rather may reflect variations in economic resources or opportunities, or other factors.

Table 1 shows that the proportion of Canadians who made donations to charitable and non-profit health organizations tends to increase with age. Just over one quarter (27%) of Canadians in the 15-24 year age group were health donors. This proportion increased to nearly half (48%) of those between the ages of 25 and 34, and increased still further to over half (56%) of those aged 35-44. Further, 60% of those aged 45-54 and 61% of those aged 55-64 donated to health organizations, while the health donor rate for those aged 65 and over dropped off only slightly to 57%, thus remaining relatively high. The value of donations made by health donors also tended to increase with age, ranging from an average yearly donation of $38 for those aged 15-24 to $72 for those aged 65 and over. In addition, those donors over age 35 showed a large difference in the average value of donations ($64-$72) compared to donors under age 35 ($38-$42).

Women (55%) were slightly more likely than men (47%) to contribute financially to health organizations.[6] The mean value of donations was exactly the same for women and men ($62), though the median value of donations differed slightly ($22 vs. $25, respectively).

Marital status also seemed to play a role in charitable giving to health organizations. Married Canadians (including those involved in common-law relationships) had a higher likelihood of being health donors (60%) than those individuals who are single (32%), separated or divorced (44%), or widowed (51%). However, those individuals who are single tended to give larger donations during the reference year ($79 on average) than those who are widowed ($72), married ($58), or separated or divorced ($53). If the median is taken as the indicator of amount of donations, however, those who are widowed tended to give the largest donations ($38) to health organizations, compared to those who are married ($25), separated or divorced ($25), or single ($20).

The likelihood of making financial donations to health organizations generally increases with education, ranging from 43% for those with less than a high school education to 64% among those with a university degree. The amounts donated to health organizations also seemed to vary among those with differing levels of education. The average amount donated during the reference year ranged from $41 for those with less than a high school education to $118 among those with a university degree. Similarly, taking the median as the measure of amount donated, amounts donated ranged from $18 among those with less than high school to $35 among those with a university education.

[6] Alternatively, 55% of health donors were females (who constitute 51% of the population aged 15 and over), and 45% of health donors were males (who constitute 49% of the population aged 15 and over).

As displayed in Table 1, employed Canadians are more likely (55%) to donate to health charitable and nonprofit organizations than unemployed Canadians (39%) and those not in the labour force (46%).[7] Amounts donated to health organizations also varied by labour force status. Employed individuals ($64), especially those working part-time ($79), tended to make higher average annual donations than unemployed individuals ($24), although those not in the labour force donated, on average, an amount ($61) similar to that donated by those who are employed. However, if the median is taken as the indicator of amount donated, the largest donation ($25) was made equally by those who are employed, those who are employed full-time, and those not in the labour force. In comparison, the amounts donated by those who are employed part-time ($20) and those who are unemployed ($10) were relatively smaller.

**A Capacity for Greater Giving?**

The ability to make financial donations to health organizations is likely to be related to the level of one's disposable household income. As shown in Table 1, the likelihood of donating to health organizations and the amount given increased with level of household income. Thus, 34% of those with a gross (pre-tax) household income of less than $20,000 donated to health organizations, and this proportion more than doubled to 69% for those with a gross household income of $80,000 or more. Further, average annual donations for those in the top income level group ($127) were more than three times as large as the average donations made by those in the two lowest income groups ($40-$41). A similar, though slightly less dramatic, trend was obtained for the median amount donated to health organizations.

Although health donors with larger household incomes tend to donate larger *amounts* than do health donors with smaller household incomes, they do not tend to contribute a greater *proportion* of their pre-tax household income. As shown in Table 2, when one's annual donation is expressed as a percentage of pre-tax (gross) household income, health donors in lower household income categories contributed a larger proportion of their income than did those in higher income categories. Thus, those health donors with a gross household income of $20,000 or less donated 0.47% of their income to health organizations, whereas health donors with a gross household income of $80,000 or more donated only 0.12% of their gross household income to health organizations.

As mentioned earlier, health donors contributed, on average, $62 to health organizations during the reference year. However, given the wide range in the values of financial donations to health organizations, the average (or mean) annual donation, which may be affected by extreme values, may provide only a limited understanding of financial contributions to health organizations. The median value provides an alternative measure of the typical amount donated to health organizations, and is not affected by extreme values. However, even the median value of contributions to health organizations ($25) does not fully capture the pattern of donations to health organizations. Indeed, as Table 3

[7] An individual's labour force status was classified as: employed (working), unemployed (looking for work), or not in the labour force (neither working nor looking for work).

indicates, a large proportion of donors contributed relatively small amounts of donations, while a small proportion of donors contributed relatively large amounts.

**Concentration of Support**

In Table 3, health donors are grouped according to the size of their total annual contributions to health organizations. Donors are grouped into three equal-sized categories based on the total amount of donations contributed to health organizations during the reference year. Thus, one-third of health donors contributed $13 or less, a second third of health donors contributed between $14 and $39, and another third of health donors contributed $40 or more. As shown in Table 3, a relatively small proportion of health donors account for a disproportionately large percentage of all financial donations to health organizations. The third of health donors who made the largest financial donations to health organizations ($40 or more) accounted for fully 84% of the total value of financial donations to health organizations. The remaining two thirds of health donors, who made annual contributions to health organizations of less than $40, accounted for the remaining 16% of all financial donations to health organizations.

**Provincial Variations**

Provincial variations in financial giving to non-profit and charitable organizations in general are dramatic and are likely to reflect differences in economic circumstances, social values, and cultural conventions across Canada. This is no less true of financial giving to health organizations. As displayed in Table 4, the highest health donor rates were found in the Atlantic provinces, with Newfoundland leading the way at 70%, followed by Prince Edward Island at 69%, Nova Scotia at 63%, and New Brunswick at 62%. Saskatchewan followed the Atlantic provinces closely with a health donor rate of 60%.

Although the Atlantic provinces displayed the highest health donor rates, donors in these provinces did not necessarily make the largest donations to health organizations. The average annual donation to health organizations was $75 in Ontario (the highest mean annual donation among all provinces) and $58 in Quebec, but only $25 in Newfoundland (the lowest mean annual donation among all provinces) and $36 in New Brunswick. Indeed, with the exception of donors in Prince Edward Island (who donated, on average, $62 to health organizations during the reference year), donors in the Atlantic provinces tended to make smaller donations to health organizations than donors in Ontario, Quebec, or Saskatchewan, or to make donations on a par with donors in other provinces. However, if the median is taken as the measure of typical amount donated, the highest amounts were donated by health donors in Ontario ($30), Manitoba ($28) and Alberta ($28), whereas the lowest amounts were donated by health donors in Newfoundland ($11) and Quebec ($15).

The differing pictures of financial giving that emerge with various measures (donor rate, mean annual donation, median annual donation) suggest caution in interpreting provincial variations in charitable giving to health organizations. Provincial and regional variations

in social and economic characteristics exist, and as mentioned earlier, such factors may influence financial contributions to health organizations, as well as other types of organizations. In addition, making financial contributions to health organizations is only one of several forms of supportive behaviour in which individuals may engage. Other supportive behaviours may include volunteer work or civic participation in health organizations. All of these factors should be considered when attempting to draw inferences about motivational factors in giving to health organizations, including inferences about generosity or other altruistic motivations.

**Community Size**

Findings from the NSGVP suggest that the size of the community in which an individual resides is associated with different rates of giving to health organizations and different amounts of giving to health organizations. For example, the findings in Table 5 suggest a possible *inverse* or *negative* relationship between the likelihood of charitable giving to health organizations and community size. That is, the health donor rate tends to increase as the size of the community decreases. The highest health donor rate (59%) is found in rural areas and communities with populations of less than 15,000 (60%), whereas the lowest health donor rate (44%) is found in communities with populations of 500,000 or greater. Further, communities with populations of intermediate size (15,000 – 29,999; 30,000 – 99,999; and 100,000 – 499,999) health rate donor rates of 56% or 57% which is relatively high in comparison to the health donor rate for the largest community size (44%) and the national health donor rate (51%).

Although different community sizes appear to be related to different amounts of giving to health organizations, the picture here is not as clear as it is for the relationship between health donor rate and community size. Health donors living in communities of 500,000 or greater contributed, on average, the largest amount to health organizations ($79), whereas health donors living in rural areas contributed the smallest average donation during the reference year ($44). However, the mean annual contributions among health donors in the remaining community sizes did not show a clear or consistent linear pattern. If the median is taken as the measure of typical amount donated, then the picture is even less clear, as amounts donated using this index vary relatively little with community size (see Table 5).

Thus, although community size does appear to be related to the likelihood of making a donation to health organizations, and community size does appear to be somewhat related to the amount of giving to health organizations, the pattern of variation is not totally consistent, particularly with respect to the relationship between community size and *amount* of charitable giving to health organizations. Still, the findings suggest that, although Canadians who live in major centres may be less likely to donate to health organizations than Canadians who live in smaller or rural areas, Canadians who live in the largest centres tend to give larger donations, on average, than Canadians who live in the smallest, or rural, areas.

## The Role of Religion

Findings from the NSGVP demonstrate the importance of taking religious factors into account when attempting to illuminate the charitable giving patterns of Canadians. This is no less true of the charitable giving patterns of health donors to health organizations. General findings from the NSGVP indicate that more than one-third of Canadians (36%) made financial donations to religious organizations and that these donations accounted for just over one-half (52%) of the total amount of all donations made. In general, donations contributed to religious organizations are larger than those made to non-religious organizations ($267 vs. $122). As was seen earlier, the average donation to health organizations during the reference year was $62. Thus, although Canadians are more likely to contribute financially to health organizations (51%) than to religious organizations (36%), the amounts donated to religious organizations are, on average, higher than the amounts donated to health organizations ($267 vs. $62).

Findings displayed in Table 6 indicate that donation rates to health organizations vary according to religious affiliation, level of church attendance, and level of religious commitment. Thus, those Canadians who stated that they were affiliated with a community of worship,[8] regardless of what the particular religious affiliation was, were more likely (54%) to contribute financially to health organizations than were those without such an affiliation (45%). Similarly, active participation in a community of worship, defined in terms of weekly attendance at religious services (whether in a church, synagogue, mosque, or other place of religious worship), is associated with a higher rate of donating to health organizations than is not attending weekly services (59% vs. 50%). In addition, those who consider themselves "very religious" were slightly more likely to make charitable donations to health organizations (53%) than those who did not consider themselves "very religious" (51%).

Table 7 focuses on the average amounts donated to health organizations by health donors, according to religious affiliation, church attendance, and level of religiosity. The findings associated with amounts donated to health organizations echo the themes discussed above concerning rates of donating to health organizations. Thus, health donors who stated that they were affiliated with a community of worship contributed, on average, somewhat higher amounts to health organizations than did those with no religious affiliation ($64 vs. $54). More dramatic, however, were the differences in average amounts contributed to health organizations by health donors who attend religious services weekly ($83) compared to health donors who do not attend religious services weekly ($55), and by health donors who consider themselves "very religious" ($92) compared to health donors who do not consider themselves "very religious" ($57). These findings illustrate, once again, the importance of religious factors in understanding charitable giving to health organizations. The findings suggest that religious affiliation, active participation in religious worship, and religious commitment may enhance the

[8] According to NSGVP findings discussed in *Caring Canadians* (Hall et al., 1998), 73% of all Canadians stated that they were affiliated with a community of worship.

likelihood of donating to health organizations or the amounts donated to health organizations.

**How Health Donors Make Financial Donations**

Health donors, like donors in general, use a variety of methods in making donations to charitable and non-profit organizations. Table 8 displays the percentage of the total *number* of all donations that were made by health donors through various fundraising methods and the percentage of the total *amount* of all donations made by health donors using each fundraising method.

The results in Table 8 indicate that the most frequent method used by health donors to make donations is by responding to a request from a door-to-door canvasser (33% of the total number of donations). This method was followed by responding to a request through the mail (16%); sponsoring someone in an event such as a walk-a-thon (15%); using other methods (including making donations in response to being asked by someone at work, telephone requests and TV/radio requests, 9%); making a donation through a collection at a church, synagogue, mosque or other place of worship (0.1%); making a donation in memoriam (15%); and responding to a canvasser in a shopping centre (5%). Other, less frequent, methods included paying to attend a charitable event (5%); making a donation through payroll deduction (1%); and approaching an organization on one's own initiative (1%). These findings suggest that door-to-door canvassers, in particular, are effective in generating contributions from health donors, and that mail requests are also relatively effective among this group of donors.

While some methods of making charitable donations are used more frequently by health donors, other methods generate a greater volume or amount of funds. For example, donations made in response to door-to-door canvassing – the most frequently used method of donating among health donors (33%) – represented only 15% of the total amount of donations made by health donors. Donations made in response to a mail request accounted for 23% of the total amount of donations, a proportion that is more comparable with its frequency of use (16%).

**The Reasons Health Donors Make Financial Donations**

The NSGVP asked a number of questions regarding the reasons why people donate to charitable and non-profit organizations. Understanding these motivations for giving may provide valuable insights not only for organizations seeking charitable support, but also for anyone interested in the contributions that Canadians make to charitable organizations. The findings below focus on the motivations for giving endorsed by health donors.[9]

[9] It is important to note that these motivations are associated with health donors rather than health donations. It was not possible to associate motivations with specific donation events - the motivations that donors list apply to all donations that they made and all organization types that they donated to.

Table 9 displays the proportion of health donors that agreed with six different reasons for giving to charitable organizations, including health and other types of organizations.[10] Most health donors agreed that the reasons for their giving are related to feeling compassion towards people in need (96%) and wanting to help a cause in which they personally believe (94%). A large majority of health donors also indicated that being personally affected by the cause that the organization supports was a motivation for giving (73%). They may, for example, have an illness or know someone with an illness that an organization supports. In addition, a majority (62%) of health donors donated because they feel they owe something to their community. In comparison, relatively few health donors gave to fulfill religious obligations or beliefs (34%), and a small percentage (12%) of health donors indicated that they give in order to obtain a credit on their income tax.

The findings above suggest the importance of altruistic factors such as compassion towards people in need and the desire to help a cause in which they personally believe as major motivations for charitable giving among health donors. However, these findings must be situated within the context of other personal and economic determinants of charitable giving, such as age, education, and income, as discussed earlier. It may be useful in future research to examine the importance of specific motivational factors for different demographic groups.

**The Role of Tax Credits**

Donors to registered charitable organizations, including health charitable organizations, are eligible to receive income tax credits for their donations. Recent federal budgets have increased the tax credits that Canadians are able to receive in an effort to encourage Canadians to increase the support that they give to charitable organizations.

Do health donors take advantage of the tax credits that are offered for their donations to health and other types of organizations? Overall, 54% of health donors indicated that they or someone else in their household would be claiming a tax credit for their charitable donations. However, this percentage varied from a high of 70% among those whose annual donations to health charities totaled $40 or more to a low of 38% among those whose annual donations to health charities totaled $13 or less (see Table 10).

Would health donors contribute more if governments offered them a better tax credit for their charitable donations? Overall, 41% percent of health donors indicated that they would increase their donations if offered a better tax credit. Once again, this percentage increased as the size of annual donation to health organizations increased. Thus, 44% of health donors who contributed more than $40 to health organizations in the previous year (the third of donors who made the largest financial contributions) reported that they would increase their donations (in general, not specifically to health organizations) if

[1010] Survey participants responded to each of six statements; they were not asked to specify their own or other reasons for giving to charitable organizations.

offered a better tax credit, compared with 37% of health donors who contributed $13 or less to health organizations during the reference year.

These findings suggest that only a little over half (54%) of health donors currently take advantage of existing tax incentives. As was seen in Table 9, only 12% of Canadian health donors reported that their charitable giving was motivated by the prospect of an income tax credit. On the positive side, however, the findings also suggest that, among health donors, stronger tax incentives for charitable giving may enhance charitable giving, especially among those who donate relatively large amounts to charitable organizations. Thus, there is reason to believe that charitable giving among health donors may be enhanced by stronger tax incentives.

**Links Between Charitable Giving and Other Forms of Support**

There are many ways in which Canadians support one another and their communities. Canadians offer their support to others through their involvement in a broad spectrum of activities, including charitable giving, volunteering, helping others directly, giving money to others directly, and participating in community organizations. Furthermore, findings from the NSGVP suggest that there are important linkages among these supportive activities. That is, an individual who engages in one supportive activity is likely to engage in other supportive activities, as well.

Table 11 shows the proportion of Canadians aged 15 and over involved in supportive activities according to the amount of annual donations made to health organizations, including zero donations. Findings indicate that health donors (see the last three columns of Table 11) are more likely to engage in all four types of supportive activities than are Canadians who did not donate to health organizations (see the first column of Table 11). Furthermore, the likelihood of involvement in these four activities increases with the amount of giving to health organizations – although the most dramatic differences are between non-donors and donors.

**Comparison of Findings on Health Donors and Health Organizations to Overall NSGVP Findings**

To a great extent, the findings related to health organizations and health donors mirror those related to the overall NSGVP findings. As was the case for health donors, the proportion of Canadians who made financial donations to charitable and non-profit organizations varies across sub-groups of Canada's population, as does the amount of charitable giving to such organizations. For both the health-related findings and the overall NSGVP findings, the likelihood and amount of charitable giving overall is positively related to age, education, and income. In general, as the levels of these factors increase, so do the likelihood and the amount of charitable giving.[11] Trends related to

[11] The positive relationship between charitable giving and age, education, and income appears even more pronounced (linear) in the overall NSGVP data than it does in the health-related data (see *Caring Canadians*, Hall et al., 1998).

gender, in which a larger percentage of women than men donate to charity, but the amounts of donations tend to be relatively similar for women and men, hold for both health organizations/health donors and the overall NSGVP picture. For example, in the overall NSGVP findings, 81% of women donated to charitable organizations, compared to 75% of men. The corresponding figures for women and men in regard to health organizations are 55% and 47%, respectively.

Findings concerning marital status and charitable giving to health organizations also parallel the overall NSGVP findings, with a few minor exceptions. While Canadians who are married or living in common-law relationships are the most likely group to donate to health organizations (60%) or to any type of organization overall (85%), there are some differences between the health data and the overall NSGVP data concerning marital status and *amounts* donated. In the overall NSGVP data, Canadians who are widowed donated the largest average ($302) and median ($121) yearly amounts to charitable and non-profit organizations. However, in the health data, Canadians who are single donated the largest average amounts to health organizations ($79), but Canadians who are widowed donated the largest median amounts to health organizations ($38).

The pattern regarding labour force status and charitable giving to health organizations is also mirrored in the overall NSGVP findings. In both the health-related data and the overall NSGVP data, employed individuals were more likely to be donors than unemployed individuals and those not in the labour force. Employed individuals, especially those working part-time, also made larger average annual donations. However, as was the case for marital status, some minor variations were found between the health-related findings and the overall NSGVP findings. For example, while those individuals who are employed part-time donated the largest average annual donation to health organizations and to organizations in general, the findings for the largest median annual donation differed between the health-related and overall findings. Among health donors, the largest median annual donation ($25) was made equally by those individuals who are employed, those individuals who are employed full-time, and those individuals who are not in the labour force. Among donors in general, the largest median annual donation ($85) was made only by those individuals who are employed full-time.

As was the case in relation to health donors, NSGVP findings overall show that donors with higher incomes tend to make larger donations than donors with lower incomes, but that the higher-income donors do not contribute a greater percentage of their pre-tax (gross) household income. Indeed, as was found for health donors, donors overall in the lowest household income category gave a larger proportion of their income in financial donations than did those in the highest income groups (1.4% vs. .4%). The comparable percentages for health donors in the lowest and highest income groups were 0.47% and 0.12%, respectively.

On the other hand, the same pattern concerning the distribution of all financial donations by size of annual donation that was found among health donors was also found among donors overall. In the overall NSGVP, the third of donors who made the largest financial donations ($150 or more) accounted for 86% of the total value of financial donations,

whereas the remaining two-thirds of donors, who made yearly contributions of less than $150, represented the remaining 14% of all financial donations. As was shown in Table 3, the third of health donors who made the largest financial donations ($40 or more) accounted for 84% of all financial donations to health organizations, whereas the remaining two-thirds of health donors, who donated less than $40, accounted for the remaining 16% of all financial donations to health organizations.

In regard to provincial variations, the themes that are evident in relation to health organizations and donors are also found in the overall NSGVP.[12] Thus, as is the case for health donors, the highest donor rates overall (82%-84%) are found among the Atlantic provinces, but donors in the Atlantic provinces also tend to make smaller donations in comparison to donors in other provinces. However, some differences between the health data and the overall NSGVP may be gleaned. For example, whereas Quebec donors overall contributed the lowest average annual donation ($127), Quebec health donors contributed the second-highest annual donation to health organizations during the reference year ($58). Still, it is worth reiterating that -- as is true for health donors and giving to health organizations -- acts of charitable giving overall are related to factors such as financial capacity to give, values and attitudes towards giving, and opportunities to give. Thus, one must be cautious in attributing variations in charitable giving to variations in generosity or other altruistic factors.

The role of religion is another area in which findings regarding health donors and health organizations parallel overall findings. As discussed earlier, over one-third of Canadians (36%) made charitable donations to religious organizations, and these donations accounted for half (52%) of the total value of all donations. In addition, Canadians who stated an affiliation with a community of worship were more likely to be donors (82%) than those without such an affiliation (67%). The comparable figures for health donors were 54% and 45%, respectively. Canadians with a religious affiliation also contributed larger average amounts during the reference year than Canadians without a religious affiliation ($271 vs. $126). The differences in amounts donated between health donors with a religious affiliation ($64) and health donors without a religious affiliation ($54) were less striking, however, than they were for Canadian donors overall.

As was true for health donors, Canadian donors overall who attend religious services weekly are more likely (90%) to make charitable donations than Canadians who do not attend religious services weekly (76%). In comparison, the relevant figures for health donors were 59% and 50%, respectively. Further, Canadian donors who attend religious services weekly contributed, on average, higher amounts during the reference year ($551) than those who did not attend weekly ($148). As was previously noted, the comparable figures for health donors were $83 and $55, respectively. Finally, Canadians who describe themselves as "very religious" are more likely to donate financially to charitable organizations and also to give more than those who do not describe themselves as "very religious." As discussed in relation to health donors and health organizations, the

[12] Variations in charitable giving according to community size was not investigated in *Caring Canadians* (Hall et al., 1998).

difference in health donor rate between those who describe themselves as "very religious" and those who do not describe themselves as such was not very large (53% vs. 51%), although the difference in average amounts donated was relatively substantial ($92 vs. $57, respectively). In general, both the NSGVP overall findings and the specific health-related findings suggest the importance of religion in understanding patterns of charitable giving.

In terms of methods of donating, the findings pertaining to health donors bear strong similarities to the findings pertaining to donors overall. Thus – as was the case for health donors – the three most frequent methods of donating overall were responding to a request from a door-to-door canvasser (19% of the number of all donations), responding to a request through the mail (15%), and sponsoring someone in an event such as a walk-a-thon (14%). The two methods that generated the greatest volume of funds were donations made through places of worship (48% of the value of all donations) and responding to a mail request (13% of the value of all donations).

In regard to reasons for making financial donations, the results for donors overall and health donors in particular were remarkably similar. Based on the percentage of donors endorsing each statement, the rank-ordering of the set of statements was the same both for donors overall and for health donors, and the percentages of endorsement were also quite similar. Overall, 94% agreed that the reasons for their giving are related to feeling compassion towards people in need; 91% wanted to help a cause in which they personally believe; 65% indicated being touched by the cause the organization supports; 58% donated because they feel they owe something to their community; 34% gave to fulfill religious obligations or beliefs; and 11% stated that they gave to obtain an income tax credit.

In relation to the role of income tax credits, the findings overall also paralleled those for health donors. Overall, 47% of donors (compared to 54% of health donors) indicated that they or someone else in their household would be claiming a tax credit for their charitable donations. As was found for health donors, the percentage overall varied according to amount of annual donation, ranging from a high of 76% among those whose yearly donations totaled $150 or more to a low of 19% among those whose yearly donations totaled $39 or less. Furthermore, 37% of Canadian donors in general (compared to 41% of health donors) indicated that they would contribute more if offered a better tax credit. Again, as was the case for health donors, the percentage increased as the size of the annual donation increased: 46% of donors contributing more than $150 annually reported that they would increase their donations if offered a better tax credit compared to 30% of those who made annual donations of less than $40.

Thus, the same trends found for health donors in regard to the role of tax credits were found for the NSGVP overall. Findings suggest that better tax credits may enhance charitable giving to health organizations as well as to other types of organizations in general. The findings also suggest that health donors may be slightly more likely than donors in general to claim a tax credit for their charitable donations (54% vs. 46%), and

to report that they would increase their donations if a better tax credit were offered (41% vs. 37%).

In regard to linkages between charitable giving and other forms of supportive behaviour, the same pattern was found in the NSGVP overall as was found for the health-related data. Canadian donors in general are more likely than non-donors to engage in other supportive activities, such as volunteering, helping others directly, giving to others directly, and participating in community organizations. Further, as was found for health donors, the overall likelihood of involvement in these activities increases as the amount that an individual gives increases.

**Comparisons Between Health Organizations and Other Types of Organizations**

As discussed in *Caring Canadians* (Hall et al., 1998), Individuals and communities in Canada benefit from the many services and programs offered by charitable and nonprofit organizations. The diverse activities in which these organizations engage range from operating food banks to supporting medical research, from providing rehabilitative services to offering job training, from providing disaster relief to offering sports and recreational programs.

Findings from the NSGVP indicate the distribution of all donations reported according to the type of organization to which the organization was made. Health organizations received the highest number of individual donations (38% of all reported donations), followed by social service organizations (21%), religious organizations (15%), education and research (7%), philanthropy and voluntarism (5%), culture and arts (4%), international (2%), environment (2%), and other (2%).[13]

In terms of total amount donated, religious organizations were the largest recipient of charitable giving. Donations to religious organizations amounted to almost $2.29 billion, more than half (52%) of the total value of all donations ($4.44 billion). As noted earlier, this is because donations to religious organizations tend to be larger than those to non-religious organizations. Health organizations were the second-largest beneficiary of charitable giving, receiving 17% of the total amount of donations, or $748 million. Health organizations were followed by social service organizations, which received $502 million, or 11% of the total value of all donations, philanthropy and voluntarism organizations (6%), education and research organizations (4%), culture and arts organizations (3%), international organizations (3%), environment organizations (2%), and other organizations (2%).

Most donors do not give to only one type of organization. Only 28% of donors restricted their giving to only one type of organization, whereas 72% of donors gave to two or more types of organizations. Among these donors, 39% supported two different types of

[13] Four types of organizations are included in this category: development and housing; law, advocacy, and politics; business and professional associations; and other organizations not elsewhere classified.

organizations, 23% supported three different types of organizations, and 19% supported four or more different types of organizations.

**Conclusion**

The findings presented in this report indicate the usefulness of the NSGVP organizational classification system for providing detailed insight into the financial support that Canadians contribute to charitable and non-profit health organizations. Variations in support are found according to personal and economic characteristics, provincial and community size variations, and religious factors. Findings also suggest the greater capacity for support among higher-income Canadians, a concentration of support, and the potential for increasing such support using tax incentives. In addition, findings suggest the particular effectiveness of door-to-door canvassers in generating charitable giving among health donors. Motivations for charitable giving among health donors include compassion towards people in need and the desire to help a cause in which they personally believe. Finally, findings suggest important linkages among various forms of charitable support (charitable giving, volunteering and participating) on the part of health donors. In general, the findings are quite consistent with those discussed in *Caring Canadians, Involved Canadians: Highlights from the 1997 National Survey of Giving, Volunteering and Participating* (Hall et al., 1998).

Such knowledge about the charitable giving patterns of the individual Canadians who donate to non-profit and charitable health organizations is vital to the continued growth and sustainability of the voluntary health sector, and will contribute to ensuring that voluntary health organizations are able to offer a wide range of services that promote the health and well-being of Canadian individuals and communities.

| Table 1 Donor Rate, Average and Median Amount of Donations to Health Organizations, Canadian Population aged 15 and over, 1997. | | | |
|---|---|---|---|
| **Characteristic** | **Donor Rate (%)** | **Mean ($)** | **Median ($)** |
| **Age** | | | |
| 15-24 | 27 | 38 | 10 |
| 25-34 | 48 | 42 | 20 |
| 35-44 | 56 | 72 | 25 |
| 45-54 | 60 | 64 | 29 |
| 55-64 | 61 | 68 | 39 |
| 65+ | 57 | 72 | 30 |
| **Sex** | | | |
| Male | 47 | 62 | 22 |
| Female | 55 | 62 | 25 |
| **Marital Status** | | | |
| Married | 60 | 58 | 25 |
| Single, Never Married | 32 | 79 | 20 |
| Widow/Widower | 51 | 72 | 38 |
| Separated/Divorced | 44 | 53 | 25 |
| **Education** | | | |
| Less than high school | 43 | 41 | 18 |
| High school diploma | 49 | 57 | 25 |
| Some post-secondary | 47 | 53 | 26 |
| Post-secondary certificate/diploma | 56 | 54 | 25 |
| University degree | 64 | 118 | 35 |
| **Labour Force Status** | | | |
| Employed | 55 | 64 | 25 |
| Full-time | 55 | 61 | 25 |
| Part-time | 53 | 79 | 20 |
| Unemployed | 39 | 24 | 10 |
| Not in labour force | 46 | 61 | 25 |
| **Household Income ($)** | | | |
| less than 20,000 | 34 | 40 | 19 |
| 20,000 - 39,999 | 50 | 41 | 20 |
| 40,000 - 59,999 | 54 | 49 | 25 |
| 60,000 - 79,999 | 58 | 53 | 25 |
| 80,000+ | 69 | 127 | 39 |
| **Total** | **51** | **62** | **25** |

**Table 2** Percentage of Household Income Spent on Financial Donations to Health Organizations by Level of Household Income, Canadian Health Donors aged 15 and over, 1997.

| Annual Gross Household Income | Percentage Donated to Health Organizations |
|---|---|
| Less than $20,000 | 0.47% |
| $20,000 - $39,999 | 0.15% |
| $40,000 - $59,999 | 0.11% |
| $60,000 - $79,999 | 0.08% |
| $80,000 or more | 0.12% |

**Table 3** Distribution of all Financial Donations to Health Organizations by Size of Annual Donation, Canadian Health Donors aged 15 and over, 1997.

| Amount of Donations | Percent of Donors | Percent of Donations |
|---|---|---|
| Donated $14 or less | 33% | 4% |
| Donated $15-$39 | 33% | 12% |
| Donated $40 or more | 33% | 84% |

| Table 4 Donor Rate, Average and Median Donations to Health Organizations by Province. Canadian Population aged 15 and over, 1997. | | | |
|---|---|---|---|
| **Province** | **Donor Rate (%)** | **Mean ($)** | **Median ($)** |
| **Canada** | **51** | **62** | **25** |
| Newfoundland | 70 | 25 | 11 |
| Prince Edward Island | 69 | 62 | 20 |
| Nova Scotia | 63 | 43 | 20 |
| New Brunswick | 62 | 36 | 20 |
| Quebec | 44 | 58 | 15 |
| Ontario | 56 | 75 | 30 |
| Manitoba | 53 | 61 | 28 |
| Saskatchewan | 60 | 41 | 20 |
| Alberta | 52 | 54 | 28 |
| British Columbia | 46 | 52 | 25 |

| Table 5 Donor Rate, Average and Median Donations to Health Organizations by Community Size, Canadian Population aged 15 and over, 1997. | | | |
|---|---|---|---|
| **Size of Community** | **Donor Rate (%)** | **Mean ($)** | **Median ($)** |
| 500,000 or Greater | 44 | 79 | 25 |
| 100,000 – 499,999 | 57 | 53 | 25 |
| 30,000 – 99,999 | 56 | 48 | 20 |
| 15,000 – 29,999 | 57 | 59 | 25 |
| Less than 15,000 | 60 | 48 | 20 |
| Rural Area | 59 | 44 | 20 |

| Table 6 | Donation Rate to Health Organizations According to Religious Affiliation, Church Attendance and Level of Religious Commitment, Canadian Population aged 15 and over, 1997. |
|---|---|
| | **Donor Rate (%)** |
| **Religious Affiliation** | |
| Yes | 54 |
| No | 45 |
| **Attends Church Weekly** | |
| Yes | 59 |
| No | 50 |
| **Consider Themselves Very Religious** | |
| Yes | 53 |
| No | 51 |

| Table 7 | Average Donation to Health Organizations Made During the 12-month Reference Period According to Religious Affiliation, Church Attendance and Level of Religious Commitment, Canadian Health Donors aged 15 and over, 1997 |
|---|---|
| | **Average Yearly Donation ($)** |
| **Religious Affiliation** | |
| Yes | 64 |
| No | 64 |
| **Attends Church Weekly** | |
| Yes | 83 |
| No | 55 |
| **Consider Themselves Very Religious** | |
| Yes | 92 |
| No | 57 |

**Table 8** Methods of Making Donations as a Percentage of Total Number of Donations and Total Value of Donations, Canadian Health Donors aged 15 and over, 1997.

| Solicitation Method | % of Total Number of Donations | % of Total Amount of Donations |
|---|---|---|
| Mail request | 16 | 23 |
| Pay to attend charitable event | 5 | 13 |
| Payroll deduction | 1 | 2 |
| Sponsor event | 15 | 9 |
| In memoriam | 15 | 20 |
| Door-to-door canvassing | 33 | 15 |
| Canvassing in shopping centre | 5 | 1 |
| Through place of worship | 0.1 | 0 |
| Approaching organization on own | 1 | 9 |
| Other | 9 | 9 |

**Table 9** Reasons for Making Donations to Charitable and Nonprofit Organizations, Canadian Health Donors aged 15 and over, 1997.

| Reasons for Making Financial Donations | Percent of Health Donors |
|---|---|
| Feel compassion towards people in need | 96 |
| To help a cause in which they personally believe | 94 |
| Have been personally affected by the cause | 73 |
| Feel they owe something to their community | 62 |
| To fulfill religious obligations or beliefs | 34 |
| For an income tax credit | 12 |

**Table 10** Percentage of Canadian Health Donors who are Claiming a Tax Credit and who would Contribute More if Given a Better Tax Credit, by Amount of Annual Donations to Health Organizations, Canadian Health Donors aged 15 and over, 1997.

| | Amount of Donations | | |
|---|---|---|---|
| | **1-$14** | **$15-$39** | **$40 or more** |
| Will claim a tax credit | 38% | 54% | 70% |
| Would contribute more if given a better tax credit | 37% | 42% | 44% |

**Table 11** Percentage of Canadians aged 15 and over Engaged in Supporting Activities by Amount of Yearly Charitable Contributions to Health Organizations, 1997.

| **Supportive Activity** | **Amount of Donations** | | | |
|---|---|---|---|---|
| | **None** | **$1-$14** | **$15-$39** | **$40 or more** |
| Volunteering | 22% | 34% | 39% | 48% |
| Helping Others | 62% | 82% | 83% | 85% |
| Giving Directly to Others | 36% | 47% | 48% | 57% |
| Involved in Community Organizations | 40% | 54% | 61% | 69% |

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## Appendix A.1 – Newfoundland Health Donors (No. of Donors = 311,738)

| *Characteristic* | *Donor rate (%)* | *Total donations ($, 000)* | *% of total donations* | *Mean ($)* | *Median ($)* |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 15-24 | 35 | 460 | 6 | 16 | 5 |
| 25-34 | 72 | 1,329 | 17 | 21 | 10 |
| 35-44 | 77 | 2,019 | 26 | 28 | 14 |
| 45-54 | 77 | 1,796 | 23 | 30 | 13 |
| 55-64 | 80 | 879 | 11 | 24 | 15 |
| 65+ | 84 | 1,171 | 15 | 24 | 10 |
| **Sex** | | | | | |
| Male | 63 | 3,761 | 49 | 27 | 11 |
| Female | 76 | 3,893 | 51 | 23 | 11 |
| **Marital Status** | | | | | |
| Married | 80 | 5,116 | 67 | 22 | 11 |
| Single, Never Married | 42 | 1,766 | 23 | 36 | 10 |
| Widow/Widower | 85 | 484 | 6 | 26 | 15 |
| Separated/Divorced | 61 | 288 | 4 | 25 | 10 |
| **Education** | | | | | |
| Less than high school | 62 | 1,813 | 24 | 16 | 7 |
| High school diploma | 59 | 814 | 11 | 21 | 10 |
| Some post-secondary | 75 | 444 | 6 | 18 | 6 |
| Post-secondary certificate/diploma | 79 | 3,034 | 40 | 31 | 15 |
| University degree | 86 | 1,549 | 20 | 46 | 20 |
| **Labour Force Status** | | | | | |
| Employed | 74 | 4,022 | 53 | 28 | 15 |
| Full-time | 74 | 3,632 | 47 | 30 | 17 |
| Part-time | 77 | 390 | 5 | 18 | 8 |
| Unemployed | 61 | 298 | 4 | 15 | 10 |
| Not in labour force | 67 | 3,335 | 44 | 23 | 10 |
| **Household Income ($)** | | | | | |
| Less than 20,000 | 64 | 1,541 | 20 | 16 | 6 |
| 20,000 - 39,999 | 71 | 1,689 | 22 | 16 | 11 |
| 40,000 - 59,999 | 72 | 1,989 | 26 | 39 | 20 |
| 60,000 - 79,999 | 69 | 1,353 | 18 | 40 | 20 |
| 80,000+ | 87 | 1,083 | 14 | 40 | 23 |
| **Total** | **70** | **7,654** | **100** | **25** | **11** |

## Appendix A.2–Prince Edward Island Health Donors (No. of Donors = 74,331)

| *Characteristic* | *Donor rate (%)* | *Total donations ($, 000)* | *% of total donations* | *Mean ($)* | *Median ($)* |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 15-24 | 26 | 119 | 3 | 23 | 20 |
| 25-34 | 65 | 338 | 7 | 25 | 20 |
| 35-44 | 90 | 792 | 17 | 42 | 23 |
| 45-54 | 85 | 704 | 15 | 46 | 30 |
| 55-64 | 68 | 374 | 8 | 47 | 20 |
| 65+ | 82 | 2,306 | 50 | 168 | 16 |
| **Sex** | | | | | |
| Male | 63 | 2,906 | 63 | 89 | 20 |
| Female | 75 | 1,726 | 37 | 42 | 20 |
| **Marital Status** | | | | | |
| Married | 83 | 3,584 | 77 | 68 | 20 |
| Single, Never Married | 38 | 555 | 12 | 49 | 25 |
| Widow/Widower | 72 | 335 | 7 | 54 | 20 |
| Separated/Divorced | 65 | 158 | 3 | 40 | 20 |
| **Education** | | | | | |
| Less than high school | 67 | 653 | 14 | 29 | 19 |
| High school diploma | 67 | 482 | 10 | 39 | 25 |
| Some post-secondary | 51 | 109 | 2 | 30 | 20 |
| Post-secondary certificate/diploma | 74 | 992 | 21 | 42 | 20 |
| University degree | 76 | 2,396 | 52 | 199 | 38 |
| **Labour Force Status** | | | | | |
| Employed | 72 | 3,605 | 78 | 79 | 25 |
| Full-time | 78 | 3,448 | 74 | 86 | 25 |
| Part-time | 47 | 157 | 3 | 28 | 10 |
| Unemployed | 66 | 112 | 2 | 20 | 15 |
| Not in labour force | 65 | 914 | 20 | 40 | 19 |
| **Household Income ($)** | | | | | |
| Less than 20,000 | 59 | 636 | 14 | 32 | 15 |
| 20,000 - 39,999 | 73 | 867 | 19 | 38 | 20 |
| 40,000 - 59,999 | 78 | 935 | 20 | 48 | 28 |
| 60,000 - 79,999 | 63 | 1,935 | 42 | 301 | 30 |
| 80,000+ | 78 | 259 | 6 | 45 | 30 |
| **Total** | **69** | **4,632** | **100** | **62** | **20** |

## Appendix A.3 – Nova Scotia Health Donors (No. of Donors = 471,479)

| *Characteristic* | *Donor rate (%)* | *Total donations ($, 000)* | *% of total donations* | *Mean ($)* | *Median ($)* |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 15-24 | 31 | 674 | 3 | 18 | 14 |
| 25-34 | 58 | 1,806 | 9 | 22 | 15 |
| 35-44 | 71 | 3,837 | 19 | 35 | 20 |
| 45-54 | 77 | 5,601 | 28 | 57 | 25 |
| 55-64 | 74 | 2,741 | 13 | 45 | 33 |
| 65+ | 72 | 5,673 | 28 | 68 | 30 |
| **Sex** | | | | | |
| Male | 59 | 8,872 | 44 | 42 | 20 |
| Female | 68 | 11,461 | 56 | 44 | 23 |
| **Marital Status** | | | | | |
| Married | 74 | 14,709 | 72 | 43 | 23 |
| Single, Never Married | 37 | 2,288 | 11 | 32 | 15 |
| Widow/Widower | 69 | 1,672 | 8 | 62 | 40 |
| Separated/Divorced | 63 | 1,664 | 8 | 51 | 20 |
| **Education** | | | | | |
| Less than high school | 52 | 4,414 | 22 | 34 | 20 |
| High school diploma | 60 | 2,975 | 15 | 45 | 20 |
| Some post-secondary | 62 | 1,216 | 6 | 38 | 18 |
| Post-secondary certificate/diploma | 70 | 7,904 | 39 | 44 | 24 |
| University degree | 82 | 3,824 | 19 | 60 | 30 |
| **Labour Force Status** | | | | | |
| Employed | 69 | 11,002 | 54 | 41 | 24 |
| Full-time | 72 | 9,214 | 45 | 42 | 25 |
| Part-time | 60 | 1,787 | 9 | 37 | 15 |
| Unemployed | 44 | 350 | 2 | 16 | 10 |
| Not in labour force | 59 | 8,981 | 44 | 49 | 20 |
| **Household Income ($)** | | | | | |
| Less than 20,000 | 44 | 3,465 | 17 | 36 | 18 |
| 20,000 - 39,999 | 67 | 5,223 | 26 | 35 | 16 |
| 40,000 - 59,999 | 70 | 5,058 | 25 | 45 | 24 |
| 60,000 - 79,999 | 74 | 3,624 | 18 | 55 | 28 |
| 80,000+ | 86 | 2,963 | 15 | 64 | 40 |
| **Total** | **63** | **20,333** | **100** | **43** | **20** |

## Appendix A.4 – New Brunswick Health Donors (No. of Donors = 371,564)

| *Characteristic* | *Donor rate (%)* | *Total donations ($, 000)* | *% of total donations* | *Mean ($)* | *Median ($)* |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 15-24 | 26 | 417 | 3 | 16 | 6 |
| 25-34 | 57 | 1,725 | 13 | 26 | 16 |
| 35-44 | 77 | 3,207 | 24 | 33 | 20 |
| 45-54 | 70 | 3,229 | 24 | 45 | 23 |
| 55-64 | 76 | 2,095 | 16 | 43 | 20 |
| 65+ | 69 | 2,767 | 21 | 44 | 23 |
| **Sex** | | | | | |
| Male | 55 | 6,029 | 45 | 37 | 16 |
| Female | 67 | 7,410 | 55 | 36 | 20 |
| **Marital Status** | | | | | |
| Married | 76 | 10,199 | 76 | 36 | 20 |
| Single, Never Married | 28 | 978 | 7 | 23 | 10 |
| Widow/Widower | 58 | 1,374 | 10 | 63 | 30 |
| Separated/Divorced | 56 | 889 | 7 | 37 | 20 |
| **Education** | | | | | |
| Less than high school | 53 | 2,790 | 21 | 25 | 12 |
| High school diploma | 62 | 2,164 | 16 | 28 | 13 |
| Some post-secondary | 47 | 1,139 | 8 | 49 | 20 |
| Post-secondary certificate/diploma | 71 | 4,298 | 32 | 37 | 20 |
| University degree | 79 | 3,049 | 23 | 73 | 40 |
| **Labour Force Status** | | | | | |
| Employed | 66 | 7,788 | 58 | 39 | 20 |
| Full-time | 68 | 6,894 | 51 | 41 | 20 |
| Part-time | 60 | 894 | 7 | 29 | 20 |
| Unemployed | 46 | 414 | 3 | 20 | 10 |
| Not in labour force | 59 | 5,238 | 39 | 35 | 15 |
| **Household Income ($)** | | | | | |
| Less than 20,000 | 47 | 2,340 | 17 | 30 | 13 |
| 20,000 - 39,999 | 65 | 3,325 | 25 | 28 | 13 |
| 40,000 - 59,999 | 66 | 3,291 | 24 | 35 | 20 |
| 60,000 - 79,999 | 66 | 1,953 | 15 | 45 | 30 |
| 80,000+ | 79 | 2,530 | 19 | 68 | 30 |
| **Total** | **62** | **13,440** | **100** | **36** | **20** |

## Appendix A.5 – Quebec Health Donors (No. of Donors = 2,474,350)

| *Characteristic* | *Donor rate (%)* | *Total donations ($, 000)* | *% of total donations* | *Mean ($)* | *Median ($)* |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 15-24 | 19 | 3,478 | 3 | 18 | 10 |
| 25-34 | 32 | 7,546 | 5 | 22 | 12 |
| 35-44 | 49 | 70,580 | 51 | 112 | 15 |
| 45-54 | 50 | 22,360 | 16 | 43 | 20 |
| 55-64 | 42 | 17,911 | 13 | 63 | 20 |
| 65+ | 45 | 16,027 | 12 | 41 | 18 |
| **Sex** | | | | | |
| Male | 35 | 43,011 | 31 | 42 | 15 |
| Female | 44 | 94,890 | 69 | 71 | 15 |
| **Marital Status** | | | | | |
| Married | 47 | 61,338 | 44 | 37 | 15 |
| Single, Never Married | 23 | 57,990 | 42 | 171 | 10 |
| Widow/Widower | 46 | 10,423 | 8 | 54 | 20 |
| Separated/Divorced | 36 | 8,150 | 6 | 49 | 15 |
| **Education** | | | | | |
| Less than high school | 35 | 19,794 | 14 | 28 | 11 |
| High school diploma | 39 | 11,654 | 8 | 33 | 12 |
| Some post-secondary | 33 | 6,857 | 5 | 44 | 21 |
| Post-secondary certificate/diploma | 43 | 24,529 | 18 | 31 | 16 |
| University degree | 49 | 75,067 | 54 | 219 | 24 |
| **Labour Force Status** | | | | | |
| Employed | 45 | 109,585 | 79 | 74 | 18 |
| Full-time | 45 | 53,110 | 38 | 43 | 19 |
| Part-time | 42 | 56,475 | 41 | 223 | 15 |
| Unemployed | 34 | 1,620 | 1 | 14 | 10 |
| Not in labour force | 34 | 26,697 | 19 | 35 | 14 |
| **Household Income ($)** | | | | | |
| Less than 20,000 | 28 | 15,236 | 11 | 31 | 10 |
| 20,000 - 39,999 | 40 | 17,089 | 12 | 26 | 11 |
| 40,000 - 59,999 | 42 | 17,152 | 12 | 32 | 17 |
| 60,000 - 79,999 | 48 | 8,224 | 6 | 28 | 20 |
| 80,000+ | 60 | 80,200 | 58 | 208 | 25 |
| **Total** | **40** | **162,934** | **100** | **58** | **15** |

## Appendix A.6 – Ontario Health Donors (No. of Donors = 5,084,840)

| *Characteristic* | *Donor rate (%)* | *Total donations ($, 000)* | *% of total donations* | *Mean ($)* | *Median ($)* |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 15-24 | 33 | 27,414 | 7 | 56 | 15 |
| 25-34 | 55 | 51,492 | 13 | 51 | 23 |
| 35-44 | 58 | 86,044 | 23 | 77 | 30 |
| 45-54 | 65 | 80,321 | 21 | 84 | 35 |
| 55-64 | 68 | 56,415 | 15 | 85 | 35 |
| 65+ | 64 | 80,286 | 21 | 94 | 41 |
| **Sex** | | | | | |
| Male | 52 | 187,067 | 49 | 82 | 28 |
| Female | 61 | 194,905 | 51 | 70 | 33 |
| **Marital Status** | | | | | |
| Married | 65 | 280,632 | 73 | 78 | 33 |
| Single, Never Married | 39 | 59,828 | 16 | 66 | 20 |
| Widow/Widower | 52 | 24,153 | 6 | 88 | 50 |
| Separated/Divorced | 50 | 17,359 | 5 | 55 | 25 |
| **Education** | | | | | |
| Less than high school | 47 | 65,240 | 17 | 55 | 20 |
| High school diploma | 54 | 72,022 | 19 | 72 | 31 |
| Some post-secondary | 53 | 32,330 | 8 | 60 | 30 |
| Post-secondary certificate/diploma | 63 | 105,272 | 28 | 71 | 30 |
| University degree | 68 | 107,108 | 28 | 122 | 45 |
| **Labour Force Status** | | | | | |
| Employed | 60 | 242,696 | 64 | 74 | 30 |
| Full-time | 60 | 212,899 | 56 | 81 | 31 |
| Part-time | 58 | 29,797 | 8 | 47 | 20 |
| Unemployed | 38 | 5,558 | 1 | 33 | 12 |
| Not in labour force | 53 | 133,717 | 35 | 81 | 35 |
| **Household Income ($)** | | | | | |
| Less than 20,000 | 35 | 29,798 | 8 | 48 | 25 |
| 20,000 - 39,999 | 56 | 56,777 | 15 | 53 | 25 |
| 40,000 - 59,999 | 58 | 70,699 | 19 | 57 | 30 |
| 60,000 - 79,999 | 61 | 57,582 | 15 | 60 | 30 |
| 80,000+ | 73 | 167,116 | 44 | 138 | 50 |
| **Total** | **56** | **381,972** | **100** | **75** | **30** |

## Appendix A.7 – Manitoba Health Donors (No. of Donors = 459,577)

| *Characteristic* | *Donor rate (%)* | *Total donations ($, 000)* | *% of total donations* | *Mean ($)* | *Median ($)* |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 15-24 | 19 | 715 | 3 | 25 | 10 |
| 25-34 | 49 | 3,294 | 12 | 42 | 17 |
| 35-44 | 65 | 7,012 | 25 | 61 | 30 |
| 45-54 | 69 | 5,318 | 19 | 56 | 35 |
| 55-64 | 65 | 5,089 | 18 | 87 | 29 |
| 65+ | 57 | 6,520 | 23 | 78 | 40 |
| **Sex** | | | | | |
| Male | 49 | 15,685 | 56 | 76 | 30 |
| Female | 58 | 12,263 | 44 | 48 | 25 |
| **Marital Status** | | | | | |
| Married | 66 | 21,920 | 78 | 63 | 29 |
| Single, Never Married | 23 | 2,589 | 9 | 51 | 16 |
| Widow/Widower | 57 | 2,329 | 8 | 58 | 35 |
| Separated/Divorced | 42 | 1,110 | 4 | 51 | 20 |
| **Education** | | | | | |
| Less than high school | 41 | 4,598 | 16 | 39 | 15 |
| High school diploma | 50 | 5,589 | 20 | 64 | 20 |
| Some post-secondary | 60 | 3,155 | 11 | 77 | 35 |
| Post-secondary certificate/diploma | 65 | 9,493 | 34 | 65 | 35 |
| University degree | 64 | 5,113 | 18 | 75 | 33 |
| **Labour Force Status** | | | | | |
| Employed | 57 | 17,374 | 62 | 55 | 26 |
| Full-time | 58 | 14,321 | 51 | 59 | 26 |
| Part-time | 53 | 3,053 | 11 | 41 | 25 |
| Unemployed | 34 | 203 | 1 | 21 | 10 |
| Not in labour force | 48 | 10,371 | 37 | 79 | 35 |
| **Household Income ($)** | | | | | |
| Less than 20,000 | 40 | 4,205 | 15 | 48 | 20 |
| 20,000 - 39,999 | 46 | 4,167 | 15 | 42 | 20 |
| 40,000 - 59,999 | 63 | 7,232 | 26 | 53 | 30 |
| 60,000 - 79,999 | 61 | 4,628 | 17 | 65 | 33 |
| 80,000+ | 67 | 7,717 | 28 | 116 | 44 |
| **Total** | **53** | **27,948** | **100** | **61** | **28** |

## Appendix A.8 – Saskatchewan Health Donors (No. of Donors = 458,425)

| *Characteristic* | *Donor rate (%)* | *Total donations ($, 000)* | *% of total donations* | *Mean ($)* | *Median ($)* |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 15-24 | 25 | 1,064 | 6 | 30 | 13 |
| 25-34 | 61 | 2,419 | 13 | 30 | 20 |
| 35-44 | 68 | 4,600 | 24 | 43 | 20 |
| 45-54 | 71 | 3,499 | 18 | 43 | 20 |
| 55-64 | 74 | 2,427 | 13 | 41 | 25 |
| 65+ | 68 | 4,946 | 26 | 52 | 26 |
| **Sex** | | | | | |
| Male | 58 | 8,057 | 43 | 37 | 20 |
| Female | 62 | 10,898 | 57 | 45 | 23 |
| **Marital Status** | | | | | |
| Married | 73 | 14,322 | 76 | 42 | 21 |
| Single, Never Married | 30 | 2,023 | 11 | 36 | 20 |
| Widow/Widower | 62 | 1,558 | 8 | 49 | 30 |
| Separated/Divorced | 55 | 1,053 | 6 | 40 | 15 |
| **Education** | | | | | |
| Less than high school | 51 | 4,979 | 26 | 38 | 18 |
| High school diploma | 60 | 3,378 | 18 | 39 | 20 |
| Some post-secondary | 53 | 1,791 | 9 | 40 | 20 |
| Post-secondary certificate/diploma | 69 | 6,216 | 33 | 44 | 25 |
| University degree | 75 | 2,591 | 14 | 47 | 30 |
| **Labour Force Status** | | | | | |
| Employed | 63 | 11,227 | 59 | 38 | 20 |
| Full-time | 67 | 8,991 | 47 | 36 | 20 |
| Part-time | 48 | 2,236 | 12 | 45 | 25 |
| Unemployed | 34 | 187 | 1 | 19 | 13 |
| Not in labour force | 59 | 7,542 | 40 | 50 | 23 |
| **Household Income ($)** | | | | | |
| Less than 20,000 | 49 | 3,179 | 17 | 36 | 20 |
| 20,000 - 39,999 | 56 | 5,095 | 27 | 41 | 20 |
| 40,000 - 59,999 | 64 | 4,024 | 21 | 37 | 20 |
| 60,000 - 79,999 | 72 | 3,448 | 18 | 44 | 25 |
| 80,000+ | 72 | 3,208 | 17 | 57 | 35 |
| **Total** | **60** | **18,955** | **100** | **41** | **20** |

## Appendix A.9 – Alberta Health Donors (No. of Donors =1,130,726)

| *Characteristic* | *Donor rate (%)* | *Total donations ($, 000)* | *% of total donations* | *Mean ($)* | *Median ($)* |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 15-24 | 26 | 3,696 | 6 | 36 | 20 |
| 25-34 | 53 | 10,915 | 18 | 46 | 20 |
| 35-44 | 57 | 15,838 | 26 | 55 | 30 |
| 45-54 | 68 | 14,062 | 23 | 60 | 38 |
| 55-64 | 55 | 7,940 | 13 | 68 | 30 |
| 65+ | 55 | 8,673 | 14 | 60 | 30 |
| **Sex** | | | | | |
| Male | 48 | 25,679 | 42 | 49 | 23 |
| Female | 56 | 35,445 | 58 | 58 | 30 |
| **Marital Status** | | | | | |
| Married | 61 | 43,502 | 71 | 53 | 26 |
| Single, Never Married | 33 | 9,660 | 16 | 49 | 20 |
| Widow/Widower | 46 | 3,986 | 7 | 77 | 70 |
| Separated/Divorced | 47 | 3,977 | 7 | 69 | 50 |
| **Education** | | | | | |
| Less than high school | 38 | 9,280 | 15 | 43 | 20 |
| High school diploma | 51 | 13,680 | 22 | 61 | 32 |
| Some post-secondary | 44 | 4,305 | 7 | 54 | 38 |
| Post-secondary certificate/diploma | 59 | 19,927 | 33 | 51 | 28 |
| University degree | 68 | 13,932 | 23 | 63 | 30 |
| **Labour Force Status** | | | | | |
| Employed | 55 | 44,863 | 73 | 53 | 30 |
| Full-time | 55 | 34,933 | 57 | 53 | 30 |
| Part-time | 53 | 9,931 | 16 | 56 | 26 |
| Unemployed | 35 | 693 | 1 | 22 | 10 |
| Not in labour force | 46 | 15,568 | 25 | 60 | 26 |
| **Household Income ($)** | | | | | |
| Less than 20,000 | 34 | 5,865 | 10 | 42 | 21 |
| 20,000 - 39,999 | 44 | 12,870 | 21 | 53 | 26 |
| 40,000 - 59,999 | 54 | 15,525 | 25 | 49 | 25 |
| 60,000 - 79,999 | 61 | 10,800 | 18 | 51 | 26 |
| 80,000+ | 78 | 16,065 | 26 | 73 | 45 |
| **Total** | **52** | **61,124** | **100** | **54** | **28** |

## Appendix A.10–British Columbia Health Donors (No. of Donors =1,422,654)

| *Characteristic* | *Donor rate (%)* | *Total donations ($, 000)* | *% of total donations* | *Mean ($)* | *Median ($)* |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 15-24 | 24 | 2,640 | 4 | 22 | 16 |
| 25-34 | 39 | 12,678 | 17 | 53 | 20 |
| 35-44 | 50 | 12,954 | 18 | 39 | 22 |
| 45-54 | 50 | 16,557 | 22 | 63 | 35 |
| 55-64 | 67 | 11,076 | 15 | 50 | 25 |
| 65+ | 51 | 17,705 | 24 | 73 | 40 |
| **Sex** | | | | | |
| Male | 44 | 35,653 | 48 | 53 | 20 |
| Female | 47 | 37,958 | 52 | 51 | 26 |
| **Marital Status** | | | | | |
| Married | 55 | 46,157 | 63 | 44 | 25 |
| Single, Never Married | 27 | 16,124 | 22 | 70 | 25 |
| Widow/Widower | 47 | 6,322 | 9 | 93 | 50 |
| Separated/Divorced | 36 | 5,007 | 7 | 58 | 40 |
| **Education** | | | | | |
| Less than high school | 37 | 8,935 | 12 | 34 | 20 |
| High school diploma | 42 | 13,286 | 18 | 49 | 30 |
| Some post-secondary | 43 | 8,133 | 11 | 45 | 28 |
| Post-secondary certificate/diploma | 48 | 24,034 | 33 | 54 | 25 |
| University degree | 64 | 19,222 | 26 | 72 | 25 |
| **Labour Force Status** | | | | | |
| Employed | 49 | 47,560 | 65 | 52 | 25 |
| Full-time | 48 | 33,124 | 45 | 48 | 25 |
| Part-time | 52 | 14,437 | 20 | 68 | 25 |
| Unemployed | 43 | 1,991 | 3 | 24 | 10 |
| Not in labour force | 40 | 24,059 | 33 | 56 | 28 |
| **Household Income ($)** | | | | | |
| Less than 20,000 | 28 | 10,120 | 14 | 53 | 25 |
| 20,000 - 39,999 | 45 | 12,587 | 17 | 38 | 20 |
| 40,000 - 59,999 | 49 | 18,935 | 26 | 58 | 25 |
| 60,000 - 79,999 | 51 | 13,728 | 19 | 52 | 25 |
| 80,000+ | 61 | 18,239 | 25 | 60 | 30 |
| **Total** | **46** | **73,610** | **100** | **52** | **25** |